



Initial Findings Report

Washington Mental Health System Assessment

November 2016

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1. Executive Summary

The state of Washington, Office of Financial Management, contracted Public Consulting Group (PCG) to examine the structure and financing of the of the mental health system, as required by Engrossed Substitute Senate Bill 6656. While state hospitals are a critical component of the state's current adult mental health system, this study addresses state hospital challenges as part of the broader continuum of care, accounting for community resources, transition planning and the funding streams that support that continuum.¹ Key findings presented here will provide the foundation for recommendations and implementation plans proposed in the "Final Alternative Options and Recommendations Report" and "Implementation and Communications Plans". These deliverables are scheduled for submission to the state on September 30 and November 15, 2016, respectively.

Our analysis is divided into three main sections as described below. First, a review of the current mental health system describes both the patient's journey through the system and how various funding streams reimburse services along the continuum. For context, the first section also includes a discussion of peer state trends and practices. Second, review of national best practices identifies significant trends in mental health system reform. Third, synthesis of stakeholder input identifies the key challenges faced in Washington today. Findings across these three areas of analysis were reviewed to identify commonly cited, significant challenges for the state, which will inform our recommendations moving forward.

The Current Mental Health System

Patients in need of mental health services may enter the continuum by a variety of means and engage in vastly different levels of care. The pathway followed by an individual is influenced by clinical need, acuity, geographic location, involvement in the criminal justice system, and other social and behavioral factors. Washington offers a wide array of treatment services for individuals with mental health conditions or symptoms. These services are largely distinguished by acute and non-acute services as well as institutional, residential and outpatient settings. Institutional services are further stratified by forensic service needs and civil services for individuals not engaged with the criminal justice system.

Navigating this continuum of services requires significant coordination and communication among the many parties involved. In reality, the full range of medical and non-medical care for people with mental health conditions in Washington state is disparate and difficult to conceptualize. This challenge reflects the breadth and complexity of the mental health infrastructure by payer type, provider type, multiple home and community based waivers, facility type and regional variation in the availability of privately administered services.

Most adult patients requiring inpatient treatment may be remanded to one of the state's two adult state psychiatric hospitals, a community hospital or an evaluation and treatment center. Lengths of stay and occupancy rates for the state psychiatric hospitals are higher than that of the other inpatient facilities. Broadly, these statistics reflect both the higher acuity and complexity of patients referred to the state hospitals and the difficulty in placing state hospital patients in safe and appropriate community-based settings on discharge.

At each stage of treatment, different payers and funding sources provide financial reimbursement for provider services. Thus, funding plays a key role in determining how successfully a patient can navigate through the

¹ Note that services and facilities specific to children and adolescents are not included in the scope of this analysis.

system. Spending on mental health services grew substantially from 2007 to present, increasing 75 percent overall. The fastest growing portion is federal funds, which grew from \$253 million to \$613 million over the decade, an increase of 142 percent. State general funds also increased 35 per cent over the same ten-year period.

Our review of data supporting the care continuum and associated funding described above resulted in the following key findings.

Key Findings

- Community resources across the continuum of care operate in disparate systems, which may complicate both a patient or provider's ability to navigate the system and the successful placement of patients in the appropriate setting.
- Hospital discharge planning faces a number of specific barriers, including lack of residential placements that fit patient needs, lack of uniform discharge protocols across hospital units and limitations in use of electronic medical records to inform post-discharge care. Other states face similar challenges in placing patients in the appropriate treatment setting. While many states moved forward with deinstitutionalization, similar challenges in appropriately funding community resources were experienced. Minnesota represents a best practice example of efficient, system-wide focus on community-based care.
- Some geographic areas of the state lack specialized community resources that offer individuals services and supports targeted to their unique needs. This is particularly true for individuals with co-morbid conditions such as significant behavioral health needs together with complex medical needs.
- Quantifying unmet need and availability of services by geographic area requires further study. Lack of a uniform and comprehensive assessment across all provider types by geographic location and their relative ability to accept new patients hinders the study of appropriate utilization.
- Unit staffing at the state hospitals is lean in comparison to the states selected for this review. Although reporting differences confound a more detailed comparison, total direct care staff to patient ratios in many of the states reviewed were 10 to 50 percent higher than Washington, meaning more staff members are available per patient in other states.

Best Practices

PCG conducted a literature review to identify best practices in several key areas, covering the revolving roles of state hospitals and community resources and various funding issues related to mental health services. Our research found that states are increasingly limiting state hospital admissions to forensic patients and a smaller portion of civil patients, mainly those with psychotic disorders and bipolar diagnoses classified as high acuity due to behavioral or complex medical conditions. States share a common challenge of identifying the optimal number of beds per capita due to a lack of consistent reporting and identification of available beds across systems as well as issues quantifying population need as individuals face hurdles entering the system.

Facility treatment is moving toward recovery-oriented principles including the use of peer support programs and substance use treatment in state hospital settings. This trend reflects broader goals of person-centered care that permeate throughout physical and behavioral health guidelines. Best practices also document the

national trend toward community-based treatment, with significant focus on crisis intervention, integrated substance use disorder and identification and management of social and environmental issues that may significantly impact patient recovery.

Broadly, states are seeking system modernization and information technology (IT) interoperability to effectively transition mental health patients through the system and integrate with physical health. Mental health providers who have moved toward electronic health record adoption cite enhanced quality assurance, improved data reporting, improved productivity, reduced billing errors and the generation of client outcome measures among key advantages.

Finally, funding mechanisms are evolving to further incentivize community care. Federal funding for institutional care continues to decline in favor of alternative, community-based models. The relationship between reduced disproportionate share funding and significant support for innovative models, such as delivery system reform incentive pools, exemplifies this trend.

Washington Perspective

To document the first-hand perspective of individuals directly involved in Washington's mental health system, PCG conducted a series of stakeholder interviews in August 2016. Stakeholders were identified by the state and included mental health providers and provider organizations, Behavioral Health Organizations (BHOs), community hospitals, advocacy organizations, criminal justice system representatives, labor unions, legislative staff, state administrators, state hospital staff and Managed Care Organizations (MCOs) operating in the full integration early adopter region. Workgroups and other consultants in the state were also consulted to identify findings to date in their area of expertise. Synthesis of input from these sources resulted in the following key findings.

Key Findings

- Community resources, both availability and accessibility, present significant challenges. Specific and significant shortfalls in affordable housing, substance use disorder services, peer support, crisis stabilization and appropriate residential facilities for individuals with co-morbid or complex conditions, represent the greatest concern. In areas where services are available, accessing those services is hindered by awareness, the ability to make appropriate connections and lack of willingness of private providers to accept high need, low income patients.
- There is perceived ambiguity and lack of standardization throughout the current system. The processes for admission to and particularly discharge from the state hospitals are not well understood among those impacted by such determinations. Compounding this issue, discharge and related evaluation protocols differ from facility to facility, creating confusion and distrust in the system.
- The state hospital system faces a number of operational challenges. For both state hospitals, continuity across units, multiple staffing issues and a lack of recovery-oriented practices (such as peer support and substance use disorder services) were cited among these challenges. Many of these issues are exacerbated for Western State Hospital, where a significantly larger portion of this population is currently served.

- Stakeholders stressed that placing BHOs at risk for state hospital beds will also require significant changes in the level of control that BHOs may exercise over the populations under the risk arrangement to effectuate real bed day utilization changes.

Major Findings

Through analysis of quantitative data, peer state comparisons, national best practices and stakeholder input, four common findings persisted. These major findings encompass issues identified through multiple data streams and represent the most significant and persistent challenges facing Washington faces.

State hospital utilization and operations face a number of challenges. High occupancy rates and a lack of alternative settings for complex patients are compounded by lean staffing models, organizational silos and a lack of recovery-oriented programming. The hospitals currently serve a broad mix of civil and forensic patients. However, best practices and current national trends suggest that state hospitals are moving toward a model that serves an increasingly limited patient demographic, mainly focused on the forensic population. Thus while capacity is strained, systemic issues may be more appropriately addressed by expanding access to alternative settings rather than increasing state hospital beds. Available utilization data from BHOs indicates significant variation in utilization of the state hospital system. However, lack of uniform allocation methodologies across regions and available acuity data confounds further analysis as to the appropriateness of such utilization.

Community based resources exist in a complex, disparate set of systems that does not effectively support complex patient needs. The challenges here are two-fold. First, there are insufficient community resources to support patients who, while having complex medical, social and behavioral needs, do not require state hospitalization. Second, services that are available may not be fully utilized as their availability is not reported or organized on a system-wide basis. Thus patients, providers and care managers alike struggle to identify available resources for patients in need. These issues are further compounded by a lack of interoperability and standardization in the systems that support these services.

Ambiguity and a lack of system-wide standardization weakens the ability of providers, BHOs and patients alike to effectively use the system. Transition into and out of state hospital settings is managed through admission waitlists and discharge readiness assessments that vary significantly across the system and within facilities. Ambiguity regarding the reasons for admission and discharge has created skepticism among stakeholders regarding the appropriateness of patient care and ultimately contributes to delays in patient placement.

National best practices for mental health funding incentivize community treatment for civil patients and emphasize the use of state hospitals for the forensic population. Reductions in federal funding for state hospitals concurrent with increased funding for delivery system reform and value-based purchasing exemplify this trend. However, effective transition toward this model requires significant focus on improving the availability and accessibility of community mental health services.

PCG acknowledges and appreciates the assistance of state staff and stakeholders in providing us with data and qualitative information necessary to complete this initial findings report. We will continue to invite and welcome feedback and suggested additions to these findings to further sharpen the view of the current system and better inform recommendations as we move forward into the next phase of our work.

2. Introduction

2.1. Purpose of the Study

The state of Washington, Office of Financial Management, contracted PCG to examine the structure and financing of the of the mental health system, as required by Engrossed Substitute Senate Bill 6656. This study is part of an ongoing, multi-faceted effort to improve access, safety and therapeutic value for patients served by Washington's mental health system. While state hospitals are a critical component of the state's current adult mental health system, this study addresses state hospital challenges as part of the broader continuum of care, accounting for community resources, transition planning and the funding streams that support that continuum.² As this study is part of a broader effort, this analysis also incorporates a review of current findings from the many workgroup and consultant work streams concurrently underway.

2.2. Purpose of this Report

This report describes the current state of Washington's mental health system and establishes a baseline comparison against peer state systems and national best practices. Our analysis of Washington's current system combines quantitative health service data with input from stakeholders representing varying needs and perspectives. Stakeholder input, supported by the findings of Washington's other workgroups and health system consultants, provides a first-hand perspective on the challenges facing Washington and barriers to reforming the system for the state's most vulnerable populations.

For comparison, data from other states serve two purposes. First, data from states with similar infrastructure and populations provide context for our evaluation – recognizing commonalities, evaluating strategies to overcome barriers, acknowledging Washington's achievements and identifying where challenges remain. Second, data from states ranked highly by national organizations quantify the gap separating Washington from states that have achieved certain measures of quality or efficiency. Highly ranked states are examined in the context of innate structural differences that may limit their applicability in Washington.

A review of national best practices then broadens the search for innovative approaches to care delivery and financing. Published case studies and treatment literature offer a progressive view of mental health in the United States, helping to create a vision for the future of Washington's mental health system.

2.3. Context of this Report

This report does not intend to pose specific recommendations. Key findings presented here will provide the foundation for recommendations and implementation plans proposed in the “Final Alternative Options and Recommendations Report” and “Implementation and Communications Plans”. Such deliverables are scheduled for submission to the state on October 21 and November 15, 2016, respectively.

²Note that services and facilities specific to children and adolescents are not included in the scope of this analysis.

3. Approach

3.1. Summary of Approach

To efficiently process the many data sources described in Section 2.2, our approach required five work streams. Table 1 below summarizes data collection and analysis processes, as well as any applicable limitations, for each work stream.

Table 1. Work Streams for Data Analysis

Work Stream	Process
Quantitative Data Analysis	<ul style="list-style-type: none"> • Confirmed with the state data points required to accurately describe Washington's current state hospital system, community resources and funding streams. • Reviewed data request with the state on July 25, 2016. • Processed data received and conducted follow up with identified sources as needed. • Incorporated data from the following sources into the analysis: <ul style="list-style-type: none"> ○ Washington State Institute for Public Policy ○ Healthcare Cost Report Information System ○ Eastern and Western State Hospital administrations ○ OTB Solutions, the state's workforce development consultant
Peer State Analysis	<ul style="list-style-type: none"> • Identified and confirmed five states for inclusion: Colorado, Illinois, Massachusetts, Minnesota and Oregon. <ul style="list-style-type: none"> ○ Colorado, Minnesota and Oregon were chosen by the state. Colorado and Oregon represent similar geographies and populations, while Minnesota offers best practices at a comparable per capita spend. ○ Massachusetts is a highly ranked state nationally, but also struggles with community resource availability. ○ Illinois' system is similarly structured around large inpatient hospitals. • Review public data sources, summarized in Appendix A. • Contacted key staff in each state and requested information not publicly available.
Best Practice Research	<ul style="list-style-type: none"> • Conducted literature review of peer-reviewed articles, case studies of relevant programs, white papers from national mental health organizations and evidence-based practices. • Summarized findings relevant to the structure and financing of the mental health system.
Stakeholder Input	<ul style="list-style-type: none"> • Conducted 20 in-person interviews from August 8 – 16, 2016 in western and eastern Washington with State-identified stakeholder groups. • Conducted 6 phone interviews for those unable to attend in-person sessions. • Reviewed input, identifying major themes and conflicting views.
Workgroup Input	<ul style="list-style-type: none"> • Identified project leads for each concurrent contract/initiative underway in Washington. • Sent introductory email to each respective lead explaining the concurrent work and requesting a phone call to discuss further and answer questions. • Established weekly meeting with project leads, beginning August 11, 2016, to support further collaboration. Meetings covered high-level deliverables, milestones, potential overlap, risks to progress as well as monitoring alignment of recommendations.

Work stream leads circulated their analyses among each other and project management staff to foster mutual understanding of the challenges and potential findings across all data sources.

3.2. Limitations and Considerations

While all identified stakeholders were interviewed during this process, time constraints limited engagement to State-identified interview subjects. Broader public comment was not included in the scope of this report. For the peer state analysis, each state reports information with degrees of variability. Thus for some data points included in this report, a simple comparison across states may lead to misinterpretation of the data. In those instances, the report includes a narrative describing the context of the data in each state.

4. Current Mental Health System

4.1. Mental Health System Overview

Washington's prevalence rates for mental health conditions are among the highest in the nation. With an estimated 24 percent of adults experiencing a diagnosable mental health condition and 7 percent meeting criteria for serious mental illness, Washington ranks third and second in the nation on these measures, respectively.³ Individuals with mental health and substance use related conditions access services across a spectrum of inpatient, residential and outpatient settings. Section 4 describes the continuum of care for Washington's mental health patients, following the patient as they navigate community services, receive inpatient care as needed and transition back into the community when they may safely continue recovery and treatment on an outpatient basis. Section 4.1 begins with a high-level, generalized view of this process to help orient the reader to the system and provide context for later subsections.

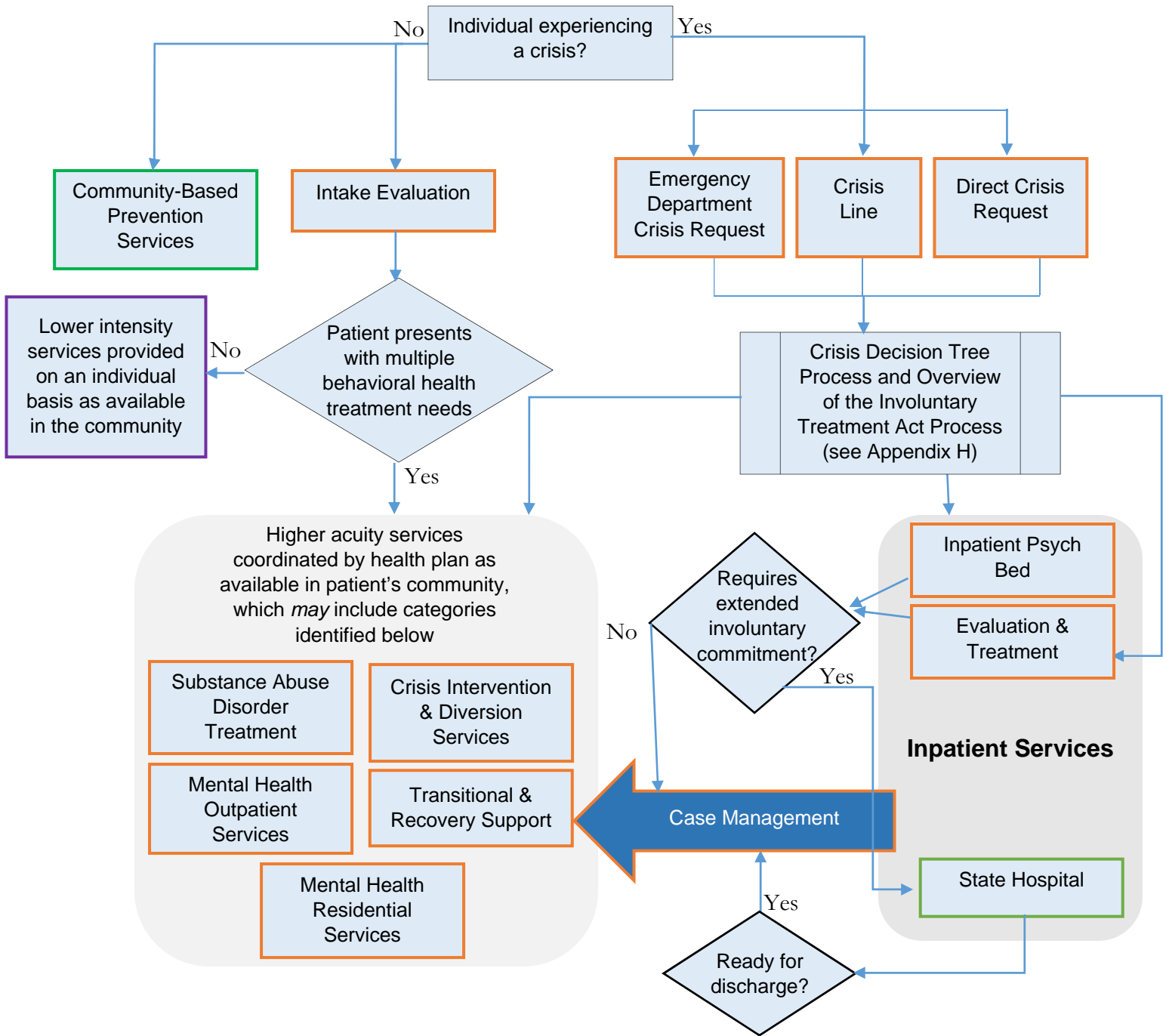
As one entryway into the continuum of care, patients may be referred to community mental health services by their medical provider or care manager or may seek out services independently. However, many patients are not referred for mental health services until they experience a crisis. Some patients in crisis will be identified and treated through community-based crisis intervention programs, but a significant portion will end up in the emergency room or otherwise detained for inpatient evaluation. If the patient may cause harm to themselves or others, or their acuity is such that inpatient treatment is required, the patient may be admitted to either a state psychiatric hospital or private hospital. When the patient is again able to safely receive treatment in the community, clinical hospital staff will work with payers and community providers to place the patient in the appropriate community setting to meet the patient's needs.

At each stage of treatment, different payers and funding sources provide financial reimbursement for provider services. Following Medicaid expansion, the Medicaid-eligible population represents a significant portion of patients served. Medicaid regulations also require shifts in funding streams under different circumstances that impact both the level of state funds expended and federal funds received. Thus, treatment and funding for Medicaid patients represents a key focal point for this section of the report. For Medicaid clients presenting with higher acuity, community services are administered by BHOs. BHOs are responsible for coordinating care for these individuals across mental health and substance use disorder treatment. As background, prior to the establishment of BHOs in April 2016, the funding and oversight of behavioral health and substance use services were separate. The Washington State Department of Social and Health Services purchased behavioral health services from Regional Support Networks (RSNs) and substance use services from counties. Currently, there are 10 BHOs in the state contracted to provide crisis and treatment services. Also as of April 2016, the southwest region of the state is considered a fully integrated managed care (FIMC) early adopter, comprised of Clark and Skamania counties. Currently, 100,982 Medicaid beneficiaries receive fully integrated care through one of two managed care plans in the FIMC region.

When a court has remanded an adult Medicaid patient to one of the state's two state-operated adult psychiatric hospitals, the BHOs are no longer responsible for the cost of care and the state, combined with available federal funding streams, funds the patient's treatment directly. Community hospital stays and other forms of inpatient and residential care, conversely, are reimbursed by the BHOs, who will also resume responsibility for the patient's cost of care on discharge from the state hospital.

³ Washington State Institute for Public Policy. February 2015. Inpatient Psychiatric Capacity and Utilization in Washington State. www.wsipp.wa.gov

Figure 1. Adult Civil Services and Funding Flow Chart



Public Funding Stream Legend

Orange Highlighted Boxes:
Medicaid
Non-Medicaid SMHC

Green Highlighted Boxes:
Federal - Other
Federal- DSH
General Funds - State

Purple Highlighted Boxes:
Medicaid

Figure 1 provides a high level review of the many pathways through which a patient may access the mental health system as a civil patient.⁴ Importantly, the breadth of services available, as well as the level of care management provided to guide patients toward appropriate services and continued treatment, varies greatly depending on both the payer and the geographic region in which the patient resides. For Medicaid clients, categories of services listed in the box denoting “higher acuity services” are provided by BHOs or the FIMC, but also vary depending on the service region, as illustrated in Section 4.8 of this report.

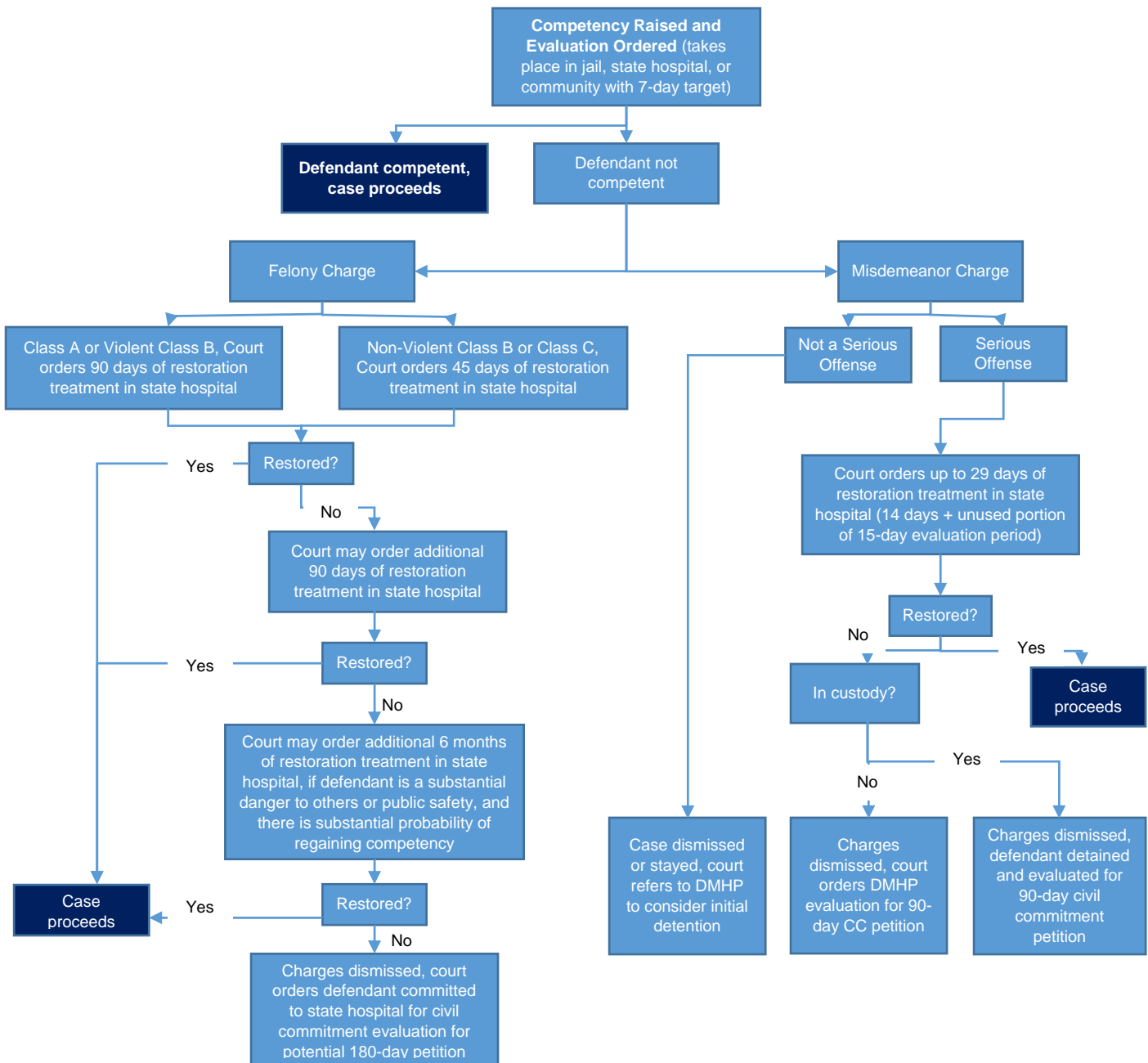
When an individual is charged with committing a crime and a court finds that the patient is not competent to stand trial or not guilty by reason of insanity (NGRI), that patient may receive mental health treatment as a forensic patient.

For patients found NGRI, the court has wide discretion in determining where the patient may be appropriately treated, ranging from court-ordered outpatient treatment for low risk individuals to commitment to a state hospital or less restrictive alternative for higher risk, higher acuity patients. Patients who are committed to a facility may progress through treatment, first demonstrating that they can successfully manage grounds privileges and second successfully re-entering the community on conditional release.

The pathway for competency restoration is more structured, albeit more complicated than the pathway for NGRI patients. Figure 2 illustrates the various pathways that forensic patients may follow for competency restoration.

⁴ A description of services available by geographic region is included in Section 4.8 of this report.

Figure 2. Competency Services Flow Chart



The remainder of Section 4 describes in further detail each phase of the care continuum and the funding sources that support treatment along the way, beginning with a description of the array of services available in Washington.

4.2. Scope of Services

As noted in Section 4.1, providers in Washington offer a wide array of treatment services for individuals with mental health conditions or symptoms. These services are largely distinguished by acute and non-acute

services as well as institutional, residential and outpatient settings. Institutional services are further stratified by forensic service needs and civil services for individuals not engaged with the criminal justice system.

When a patient is seeking care in the community, the provider receiving the patient will begin with an intake evaluation. This process aims to identify the patient's care needs and support development of an appropriate treatment plan. For BHO clients, the treatment plan may refer the patient for services such as individual, group or family counseling, medication monitoring or more intensive services such as day support or residential treatment. Therapeutic psychoeducation is also available to educate patients about their condition, treatment options and available supportive services.

Crisis care represents a large share of overall acute care services in Washington. Given that these services are rendered when a patient is in crisis, intake evaluation is not required prior to receiving help. Crisis care can take many forms, ranging from stabilization services in the patient's home or community to care provided on an inpatient basis by both licensed Evaluation and Treatment (E&T) centers and community hospitals. For inpatient crisis care, community hospitals provide a full range of physical health services, while E&T centers specialize in mental health. For BHO clients requiring inpatient care, rehabilitation case management services are intended to coordinate inpatient and outpatient services. If a patient is remanded to state psychiatric hospitalization, the BHO is required to coordinate transitional care with the state hospital to support the patient's admission and discharge.

The continuum of services described above requires significant coordination and communication among the many parties involved. In reality, the full range of medical and non-medical care for people with mental health conditions in Washington state is disparate and difficult to conceptualize. This challenge reflects the breadth and complexity of the mental health infrastructure by payer type, provider type, multiple home and community based waivers, facility type, regional variation in the availability of privately administered services and the need for multiple agencies to fund and coordinate care for a single patient.

For example, most state mental health services are provided by the BHOs that are under contract with the Department of Social and Health Services (DSHS).⁵ PCG has excerpted service provision requirements included in the BHO contracts into Appendix C. This service listing is further supported by excerpts from the DSHS Behavioral Health Benefits Book, which presents BHO services in a more complete, consumer-friendly format. Less intensive mental health services are also provided in Medicaid directly through Apple Health managed care organizations without referral to BHOs.

At the DSHS website, links to each BHO provide links to the names of community agencies that coordinate inpatient and outpatient care. Beyond the stratification of care into crisis, inpatient and residential, outpatient counseling and pharmacy, more granular information becomes provider-focused. Standardized information that targets service types by need, acuity and diagnosis are lacking. BHOs describe their services in their own unique formats, as presented to consumers. No single, streamlined menu of local mental health services is used as a common template by the BHOs. Although the Medicaid State Plan requires a formal intake process for Medicaid eligible patients to access services, providing patients with standardized information on the services available may allow patients and their caregivers to engage in an informed conversation with their provider about their treatment plan.

⁵ As noted in Section 4.1, there is one region of the state that is considered a fully integrated managed care (FIMC)/early adopter, the Southwest Washington (SWWA) RSA, comprised of Clark and Skamania counties. Medicaid beneficiaries have two fully integrated managed care plans to choose from in SWWA: Molina Healthcare of Washington and Community Health Plan of Washington. As of April 2016, 100,982 Medicaid beneficiaries receive fully integrated care through the two managed care plans.

Counties in Washington state sometimes further document all local, private, not-for-profit services, both medical and non-medical, available to consumers of mental health services. These “toolkits” are largely informational and do not reflect any state certification or recommendation for care. Services may be stratified by specific cultural emphasis or for specific consumer types by gender, ethnicity or other classification, such as military veterans.

Appendix C provides a full inventory of services by several provider categories identified during this analysis. Many sections of this inventory focus on inpatient care and assisted living, while person-centered programs, such as psychosocial rehabilitation, vocational rehabilitation and intensive care management are underrepresented. This inventory speaks to the need for system-wide service organization described above. Although many options for treatment exist, guiding patients to the appropriate care to meet their needs requires clear and common understanding of (1) the options available and (2) standards for appropriate utilization.

4.3. Determination of Need for Inpatient Care

As noted in Section 4.2, a subset of individuals requiring mental health services will be admitted to inpatient care, either in a community hospital, evaluation and treatment center or court ordered to a state psychiatric hospital for treatment. The role of state hospitals has evolved over the last several decades, as detailed in Section 5 of this report. State hospital admissions today represent a narrowed focus on forensic patients and high acuity patients with severe and co-occurring behavioral or medical complications.

Consistent with this trend, Washington state law defines parameters for state psychiatric hospital utilization as follows. RCW 72.23.025(1) states “It is the intent of the legislature to improve the quality of service at state hospitals, eliminate overcrowding and more specifically define the role of the state hospitals. The legislature intends that Eastern and Western State Hospitals shall become clinical centers for handling the most complicated long-term care needs of patients with a primary diagnosis of mental disorder.”

For forensic patients, competency evaluation is provided: (1) in jails with a target for completion within seven but no more than 14 days unless good cause is determined; (2) on an inpatient basis at the state hospitals within seven days of the signing of a court order; or (3) while the individual is released on personal recognizance. Following evaluation, competency restoration services are provided in either the state psychiatric hospitals or the recently opened Maple Lane and Yakima facilities and admission is required within seven days of the signing of a court order.

If the patient is found not guilty by reason of insanity (NGRI), they may be placed in the least restrictive setting that is appropriate for their treatment and risk level. If a patient may be safely placed on conditional release, they may reside anywhere approved by the committing court, while monitored by the forensic therapist and Community Corrections Officer. NGRI patients who are committed to the state hospitals must be assessed by the Public Safety Review Panel (PSRP) regarding potential risk to public safety before their proposed conditional release or final discharge. The PSRP was created by the legislature in 2010 to independently assess individuals and advise the Department of Social and Health Services and the courts on these matters. Commitment determinations are described at RCW 10.77.040 and require the jury to answer a series of questions about the individual, such as whether the person poses a substantial danger to others and whether it is in the person’s best interest to be treated outside of the state hospital. Expert testimony may also be provided to support community placement.

For civil (non-forensic) patients, referral for inpatient care may follow one of four main pathways. If the patient is willingly seeking services, the patient will be assessed for voluntary inpatient treatment and admitted

to an inpatient facility based on the level of need and the availability of a bed. For those patients who have previously engaged in care, the patient's case manager or referring provider may coordinate with the inpatient facility to support transition.

The remaining three pathways involve involuntary commitment to treatment, either through community hospitals, through revocation of less restrictive alternatives or following the conclusion of the competency determination process and dismissal of charges.⁶

After a 72-hour detention, the court may order a 14-day detention if continued treatment is recommended. In fiscal year 2015, 14,151 distinct individuals received an initial 72-hour involuntary treatment examination. Of these, 7,526 (53.1 percent) were detained. Individuals requiring 14-day detention may be placed in an Evaluation and Treatment (E&T) Center. In 2015, approximately 4,200 unique individuals were placed in one of the 14 E&T Centers. As noted in Section 4.4, E&T Centers typically require that admitted patients are medically stable. Those who do not meet this condition are more appropriately treated in a community hospital with psychiatric beds. As of December 1, 2015, there were 13 community hospitals in the state that were certified for involuntary admissions. These facilities staffed 453 beds at an average occupancy rate of 83 percent.⁷ At that time, there were nine hospitals certified to admit those who voluntarily sought treatment. These hospitals staffed 151 beds with an average occupancy of about 68 percent.

Under Washington Administrative Code, a single bed certification permits a licensed facility to admit and temporarily treat an individual even if that facility is not currently certified to treat involuntary patients.⁸ Such facilities used single bed certifications to treat an average of 670 patients from October 2015 to March 2015. The number of hospitals holding single bed certifications increased from 36 in December 2014 to 62 in March 2016.⁹ Following a 14-day detention, the court may order 90-day and 180-day extensions, as clinically appropriate. This decision occurs independent of BHO involvement.

In an effort to encourage development of community-based treatment options, each BHO is allotted a specified number of state hospital beds. The allocation methodology is authorized at RCW 71.24.310 and has three components:

1. The method used to calculate the beds allocated to BHOs must include the prevalence of mental illness and utilization.
2. The BHO must pay for bed use over its allocation.
3. Such payments are split evenly between the hospitals and the BHOs that did not exceed their bed allocation.

A more thorough review of this methodology and its implications are addressed in Section 5.4.

Tables 2 and 3 present the 2015 annualized average utilization data for areas served by the current BHOs and early adopter FIMC plan.¹⁰ At the time that this data was collected, these regions were served by RSNs. Issues encountered when cross referencing RSN regions to BHO/FIMC regions are described in the footnotes of each table.

⁶ Please see Appendix H for an Overview of the Involuntary Treatment Act Process.

⁷ Washington State Institute for Public Policy, data received August 2016.

⁸ Washington Administrative Codes at WAC 388-865-0500.

⁹ <https://www.dshs.wa.gov/bha/division-behavioral-health-and-recovery/mental-health-reports>

¹⁰ Please note the following caveats: Slight discrepancies in BHO client attribution due to unique circumstances such as: transient clients, clients whose legal payee resides somewhere other than where the client receives services, client who needed specialized care where no facility is available locally, etc. The state hospitals use different methodologies for attributing clients to BHOs, which create discrepancies between data from the BHOs and data from the state hospitals. This data represents the latest BHO client attributions, and does not take into account any changes in attribution from contestations from BHOs.

Three BHO/FIMC regions, all operating in the western region of the state, used more than 100 percent of their bed allocations on an annualized basis in 2015.¹¹ Note that this data does not account for month over month variation in utilization or the relative acuity of patients referred for treatment. State staff indicated that BHOs in the eastern region collectively developed and implemented their own allocation methodology that meets statutory requirements. Conversely, BHOs in the western region were unable to reach agreement on a methodology and are, therefore, subject to allocations defined by the state. Thus apparent differences in utilization in the eastern and western regions are not necessarily indicative of broader differences in community services in these regions.

Importantly, bed utilization is impacted by both admission and discharge processes. With respect to admission, the court system independently determines whether a patient will be involuntarily committed to a state hospital. The BHOs do not participate in the ultimate admission decision. However, discharge from the state hospital may be directly influenced by the availability of appropriate community treatment options. Availability of such resources is, at least in part, influenced by BHO investment in that region. Further discussion of community resource availability as a potential barrier to discharge can be found in Section 4.6.

Table 2. Eastern State Hospital BHO Bed Allocations and Utilization (SFY 2015)

BHO Name	Bed Allocations	Allocated Bed Days	Bed Days Used	Utilization %
North Central Washington BHO*	27	9,855	4,698	48%
Greater Columbia BHO	55	20,075	14,050	70%
Spokane County Regional BHO**	110	40,150	37,174	93%
King County BHO	-	-	806	*
North Sound BHO	-	-	357	*
Salish BHO	-	-	-	*
Optum Pierce BHO	-	-	239	*
SW Washington FIMC	-	-	92	*
Thurston Mason BHO	-	-	-	*
Great Rivers BHO	-	-	26	*
Total	192	70,080	57,442	82%

*North Central BHO utilization data does not include utilization from Grant County, due to lack of county level data to fully convert utilization data from RSNs to BHOs.

**Spokane BHO utilization data includes utilization from Grant County, due to lack of county level data to fully convert utilization data from RSNs to BHOs.

Data Source: Utilization data provided from Consumer Information System. Bed allocation data is based on Exhibit 3D of current BHO contract.

¹¹ At the writing of this report, more recent data was not available to determine whether implementation of the FIMC has impacted this utilization level.

Table 3. Western State Hospital Bed Allocations and Utilization (SFY 2015)

BHO Name	Bed Allocations	Allocated Bed Days	Bed Days Used	Utilization %
North Central Washington BHO	-	-	-	*
Greater Columbia BHO	-	-	65	*
Spokane County Regional BHO	-	-	62	*
King County BHO	222	81,030	83,712	103%
North Sound BHO	112	40,880	39,111	96%
Salish BHO	32	11,680	9,488	81%
Optum Pierce BHO	89	32,485	34,279	106%
SW Washington Fully Integrated Managed Care**	39	14,235	16,753	118%
Thurston Mason BHO	33	12,045	11,327	94%
Great Rivers BHO***	30	10,950	6,077	55%
Total	557	203,305	201,174	99%

*BHO is not allocated beds for this region.

** Southwest FIMC utilization data includes utilization from Cowlitz County, due to lack of county level data to fully convert utilization data from RSNs to BHOs.

*** Great Rivers BHO utilization data does not include utilization from Cowlitz County, due to lack of county level data to fully convert utilization data from RSNs to BHOs.

Data Source: Utilization data provided from Consumer Information System. Bed allocation data is based on Exhibit 3D of current BHO contract.

4.4. Initiating Inpatient Care

As described in Section 4.3, a patient requiring inpatient hospitalization may first receive such care in an evaluation and treatment center or community hospital setting. We begin this section by examining differences in the diagnostic makeup of patients treated at the state hospital, community hospitals, evaluation and treatment (E&T) centers and in an outpatient setting.

Populations Served

Table 4 below compares the primary diagnoses of individuals receiving mental health services in Washington in 2015, organized by system-wide prevalence. Note that individuals originally treated in community hospitals and later admitted to a state hospital would be represented in both columns.

In 2015, approximately 180,000 individuals received an outpatient service.¹² Of these patients, just over 1 percent were also admitted to a state hospital. That year, the state hospitals provided approximately 286,200 days of care.¹³

As illustrated in Table 4, 66 percent of all 2015 admissions to the state hospitals were related to psychotic disorders and 14 percent were related to mania/bipolar conditions. The state hospitals also had a slightly higher drug related diagnosis rate at roughly 5 percent of all admissions. Stakeholders interviewed for this analysis indicated that Washington lacks sufficient residential options for substance use disorder patients, which may contribute to their continued admission to state hospitals. Conversely, depression and anxiety are the two largest diagnoses encountered in outpatient programs.

¹² Query search in System for Communicating Outcomes, Performance & Evaluation (SCOPE). See <https://www.dshs.wa.gov/node/8941> Different state data sources provide different estimates of the number of persons receiving outpatient services.

¹³ The System for Communicating Outcomes, Performance & Evaluation (SCOPE) query.

This mix of diagnoses across facility types is consistent with observations in other states. Less than 3 percent of the state hospital population presents with a primary diagnosis of dementia and less than 0.04 percent have a primary diagnosis of developmental disability. Community hospitals show a slightly lower percent presenting with dementia, at just over 1 percent and slightly higher incidence of developmental disability, at less than 0.42 percent. Although ideally individuals with primary diagnoses of developmental disabilities and dementia would be treated in facilities tailored to those specific needs, inpatient admissions are not uncommon for these patients, especially when the patient presents a suicide risk or is experiencing a crisis.¹⁴ Lack of long-term facilities equipped to treat such patients likely also plays a role in their few but continuous admissions to the state hospitals, as discussed in other sections of this report.

Table 4. Primary Mental Health Diagnosis at Admission or Intake by Facility Type, 2015

Calendar Year 2015	Community Hospitals	Evaluation & Treatment	Community Outpatient	State Hospitals
Diagnosis Category	% of Total	% of Total	% of Total	% of Total
Depression	26.5%	22.6%	34.5%	2.4%
Anxiety	3.0%	3.1%	23.3%	0.9%
Psychotic	32.1%	40.3%	9.9%	66.5%
Mania/Bipolar	22.9%	17.9%	9.7%	14.1%
Other/Unspecified/Misc.	2.4%	0.52%	13.1%	3.22%
Adjustment	1.6%	0.8%	3.5%	0.8%
Disrupt/Impulse/Conduct	1.7%	0.3%	2.3%	< .02%
ADHD	0.4%	0.3%	2.1%	< .02%
Drug Use	3.9%	1.3%	0.5%	4.6%
Delirium/Dementia	1.2%	< .02%	0.4%	2.4%
Alcohol Use	3.2%	0.3%	0.3%	0.9%
Missing	0.0%	11.9%	0.0%	3.4%
Personality	0.4%	< .02%	0.2%	< .02%
Pervasive Developmental	< .4%	< .02%	0.1%	< .02%
Developmental	< .02%	< .02%	0.0%	< .02%
Dissociative/Conversion	0.3%	< .02%	0.0%	0.0%
Eating Disorder	0.1%	0	0.0%	0.0%
Total Persons Served	7,767	4,379	179,373	2,814

Data Source: Data provided by the Department of Social and Health Services Research and Data Analysis team.

Although useful, diagnosis data alone provides little insight into the appropriate treatment level required. During the course of this analysis, hospital administrators and other stakeholders confirmed that there is no standardized acuity assessment across, or even within, these facilities. Thus, the acuity level of individuals with a psychotic disorder diagnosis in a community hospital cannot be directly compared to individuals with the same diagnosis in the state hospitals, E&T centers or served in an outpatient setting.

¹⁴ Ziegenbein, et al. [BMC Health Serv Res.](#) 2006; 6: 150.

E&T Centers have a high proportion of psychotic disorder and mania/bipolar patients. However, E&T centers are designed for short term stays with average length of stays of 8 to 22 days. About 55 percent of stays at community hospitals involve diagnoses of psychosis or mania/bipolar and one-quarter of all stays involve depression. The average length of stay in a community hospital's psychiatric unit in 2015 was 11.5 days. Community hospitals in general continue to provide an important treatment resource, providing approximately 183,000 days of psychiatric care in calendar year 2015.¹⁵ However, the average length of civil length of stay at Western State Hospital in 2015 was 11 months, suggesting that many of the community hospital patients may eventually be transferred to the state hospital for longer treatment courses.

Community Hospital and E&T Facility Utilization

With an understanding of the range of diagnoses that may present in an E&T center or community hospital, the remainder of this subsection will identify the relative capacity and utilization of these inpatient facilities. Freestanding E&T centers offer short term psychiatric treatment for high acuity patients who do not require additional physical health monitoring or treatment. E&T centers may represent the first phase of inpatient treatment for many patients. As shown in Table 5, these facilities are not intended to support longer lengths of stay, averaging 14 days for most patients. Involuntary 72-hour detentions and 14-day court-ordered commitments occur in this type of facility. Note that the number of beds for all but one of the facilities in Table 5 is limited to 16. Federal funding for Medicaid patients is limited to E&T facilities with 16 beds or less.

Table 5. Freestanding Evaluation and Treatment Center (CY 2015)

Facility name	City	Beds	Average daily census	Occupancy Rate*	Annual admissions	Average length of stay (days)
Thurston County E&T Center (BHR)	Olympia	15	13.9	93%	380	18.9
Telecare Recovery Partnership (Telecare)	Lakewood	16	15.6	98%	271	22.0
Snohomish (Compass Health)	Mukilteo	15	n/a	n/a	n/a	n/a
Navos Inpatient Services	Seattle	34	31.9	94%	755	15.6
Kitsap Mental Health Services - adult	Bremerton	15	14.7	98%	369	14.7
Greater Lakes Recovery Center (GHMC)	Parkland	16	15.5	97%	336	17.1
Foothills (Frontier Behavioral Health)	Spokane	16	15.0	94%	645**	8.6
Kalispell (Frontier Behavioral Health) *	Spokane	16	15.0	94%	645**	8.6
Clark County Telecare E& T Center	Vancouver	11	8.3	75%	261	11.8
Bridges (Comprehensive Mental Health)	Yakima	16	11.5	72%	405	10.4
Recovery Pathways (Recovery Innovations)	Lakewood	16	13.4	84%	231	21.7
North Sound Telecare E&T (Pioneer)	Wooley	16	13.7	86%	298	16.7
MDC Evaluation and Treatment Center	Tacoma	16	12.6	79%	210	18.9
Total		218	181.1	83%	4806	14.2

*Approximated from available data

**Assumes even distribution of admissions to Foothills and Kalispell based on even distribution of beds. Data received for these facilities was combined.

Data Source: Washington State Institute for Public Policy Annual Report, 2015

Psychiatric units in community hospitals offer an additional resource for inpatient treatment for some patients. Unlike E&T centers, community hospitals can support patients with chronic medical conditions and other physical health needs in an inpatient setting. Tables 6 and 7 identify 21 community psychiatric hospital units providing certified involuntary (13) and voluntary (8) treatment beds. Two thirds of these units are owned by

¹⁵ Washington State, Department of Health, Comprehensive Hospital Abstract Reporting System (CHARS) see <http://www.doh.wa.gov/DataandStatisticalReports/HealthcareinWashington/HospitalandPatientData/HospitalDischargeDataCHARS>

voluntary, non-profit (VNP) organizations. Occupancy rates for these units are lower overall than beds in state hospitals, supporting an average length of stay from five to 24 days. As discussed in Section 4.7, charges per day for community hospitals are significantly higher than the cost per day for state hospital beds, which may partially explain differences in utilization. Patients in voluntary treatment units experience considerably shorter lengths of stay than those in involuntary units. Auburn Regional is the exception to this rule. This unit serves the geriatric population which, as previously noted, poses challenges in securing appropriate residential or outpatient treatment.

Table 6. Certified Involuntary Treatment Beds

Name	City	Hospital Ownership*	Total Beds	Average Daily Census	Occupancy Rate**	Annual Admissions	Average Length of Stay
Cascade Behavioral Health	Tukwila	P, C	48*	36.0	75%	825	16.6
Fairfax	Kirkland	P, C	107*	91.2	85%	3,352	10.2
Fairfax –Snohomish	Everett	P, C	30	24.2	81%	638	14.0
Harborview Medical Center	Seattle	G, County	61*	56.0	92%	1,285	16.1
Lourdes Counseling Center	Richland	VNP, Church	20	14.8	74%	535	10.2
Navos IMD (West Seattle)	Seattle	VNP, Other	40	36.8	92%	767	18.2
Northwest Hospital (geriatric)	Seattle	VNP, Other	27	24.0	89%	395	23.3
Peace Health St. John	Longview	VNP, Church	22	14.7	67%	611	9.0
Peace Health St. Joseph's	Bellingham	VNP, Church	20	14.6	73%	493	11.1
Providence Sacred Heart	Spokane	VNP, Church	28†	27.0	96%	1,027	9.8
Skagit Valley Memorial Hosp.	Mt. Vernon	G, Hospital	15	7.8	52%	346	8.3
Swedish Medical Center	Edmonds	VNP, Other	23	20.2	88%	523	14.6
Yakima Valley Memorial Hosp.	Yakima	VNP, Other	12^	8.9	74%	282	11.5
Total Certified Involuntary Treatment Beds			453	376.2	83%	11,079	12.7

*P = Proprietary, C=Corporation, G= Governmental, VNP = Voluntary Non-Profit

**Approximated from available data

Data Source: Washington State Institute for Public Policy Annual Report, 2015¹⁶

¹⁶ Data is based on the 2015 Washington State Institute for Public Policy Annual Report, as this is the last complete set of adjudicated utilization data available. Additional beds have been added since 2015.

Table 7. Certified Voluntary Treatment Beds

Name	City	Hospital Ownership Type*	Total Beds	Average Daily Census	Occupancy Rate**	Annual Admissions	Average Length of Stay
Auburn Regional (geriatric)	Auburn	VNP, Other	38	24.0	63%	442	20.5
Overlake Hospital Medical Center	Bellevue	VNP, Other	14	11.2	80%	836	4.9
Peace Health Southwest Washington	Vancouver	VNP, Other	14	12.7	91%	393	9.4
Providence St. Peter Hospital	Olympia	VNP, Church	17	15.9	94%	699	8.3
St. Joseph (CHI Franciscan)	Tacoma	VNP, Church	23	20.9	91%	1,167	6.5
Swedish Medical Center - Cherry Hill	Seattle	VNP, Other	10	9.6	96%	422	8.5
University of Washington	Seattle	G, State	14	9.9	71%	419	8.8
Cascade Behavioral Health (geriatric) ***	Tukwila	P, C	21				
Total Certified Voluntary Treatment Beds			151	104.2	69%	4,378	8.6

*P = Proprietary, C=Corporation, G= Governmental, VNP = Voluntary Non-Profit

**Approximated from available data

***Included in total Cascade data. Discrete information for voluntary geriatric beds not available.

Data Source: Washington State Institute for Public Policy Annual Report, 2015

4.5. State Hospital Utilization

Once patients are transferred to a state hospital, their inpatient stay can be divided into three main time periods: admission, treatment and recovery and discharge. This subsection will explore each of these areas, including relevant statistics describing the patients who are hospitalized and how they are managed by the hospital.

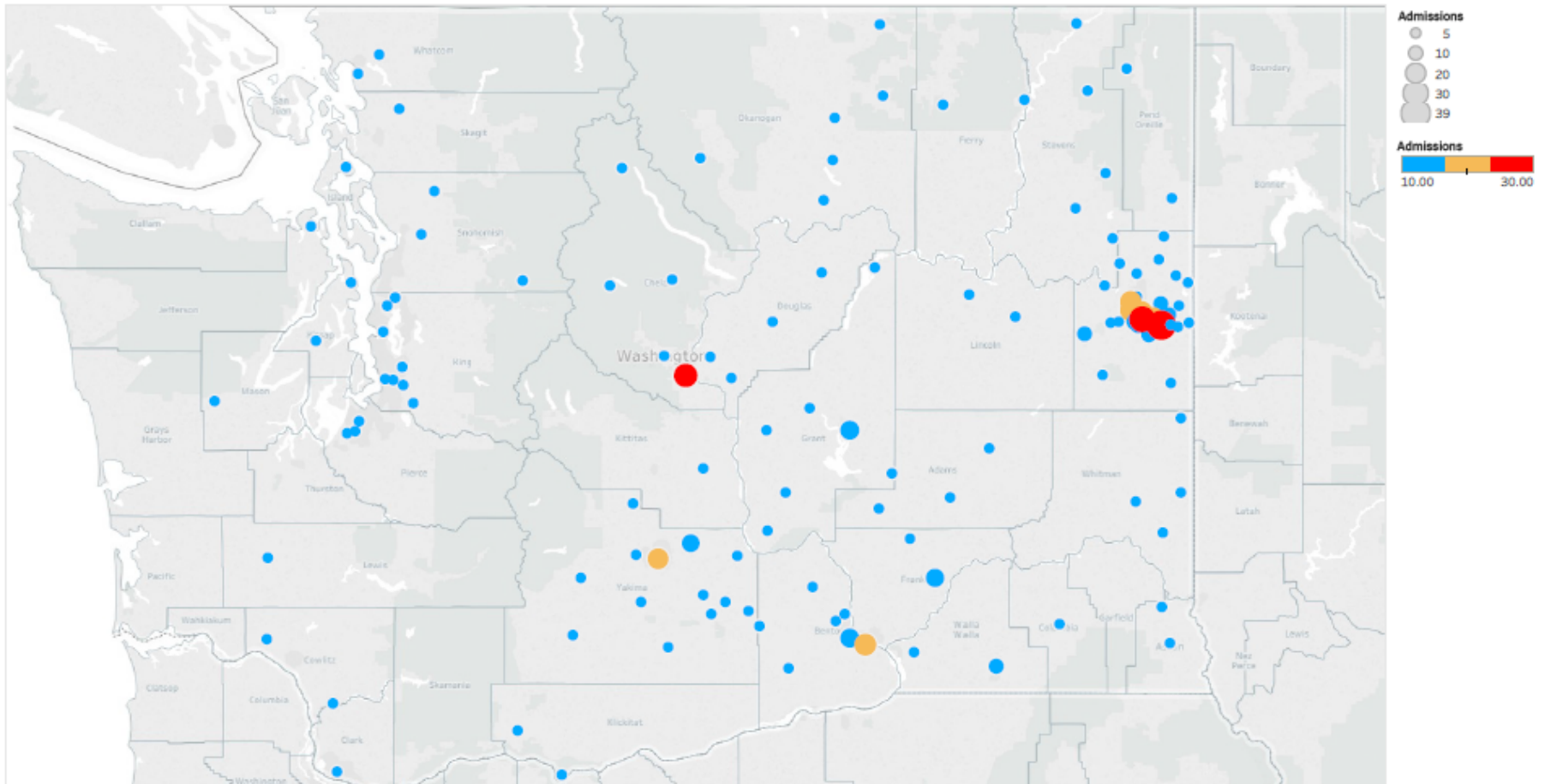
Admission

We begin by identifying trends in the demographic and clinical characteristics of patients admitted to a state hospital. As geographic location can impact both access to services and the prevalence of chronic conditions, understanding where patient referrals originate can help identify potential areas of focus. State hospital admissions are divided geographically, with Eastern State Hospital serving the eastern region of the state and Western State Hospital serving the western region. Figures 3 and 4 map admissions to Eastern and Western state hospitals by patient zip code. The map presents total admissions for state fiscal year 2015. For Eastern State Hospital, the top three sources of admission are Spokane, Wenatchee and Yakima. For Western State Hospital, the top three sources of admission are Lakewood, Seattle and Everett. Both Lakewood and Everett show higher admissions per capita than the Seattle area.¹⁷

¹⁷ Note that residence zip code at admission is not reported to DBHR by the state hospitals. For the data provided here, the Research and Data Analysis (RDA) Client Services Data Base (CSDB) was used. CSDB includes administrative data for all people served by DSHS and HCA (among other state agencies). Using all available sources, geography is determined for a person within a date range, using an algorithm. Court data are not included in the process that establishes location.

Figure 3. Eastern State Hospital Admissions by Zip Code (SFY 2015)

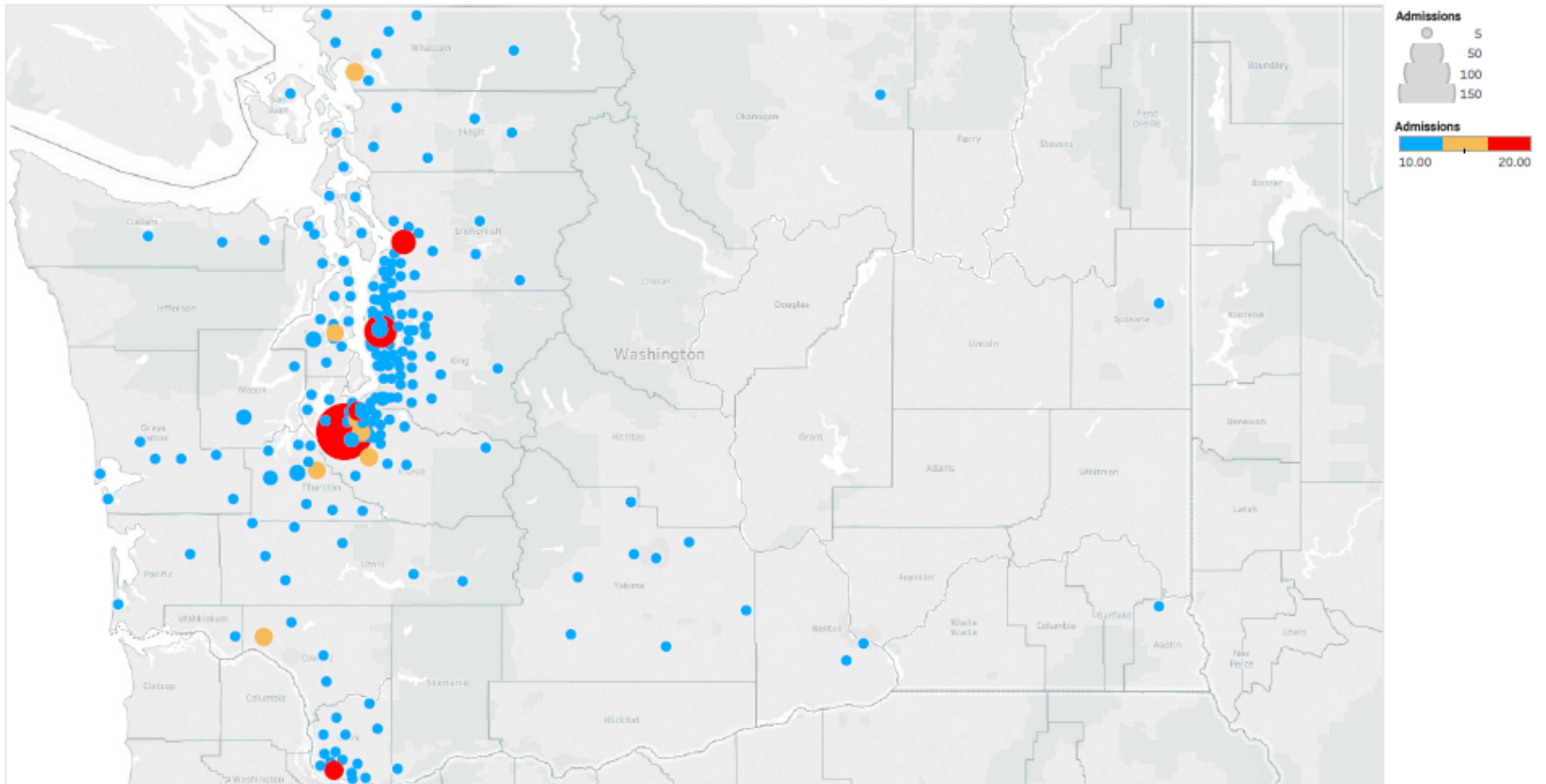
Eastern State Hospital Admissions by Zip Code



Map based on Longitude (generated) and Latitude (generated). Color shows sum of Admissions. Size shows sum of Admissions. Details are shown for Zip Code. The data is filtered on Hospital, which keeps ESH. The view is filtered on sum of Admissions, which ranges from 5 to 50.

Figure 4. Western State Hospital Admissions by Zip Code

Western State Hospital Admissions by Zip Code



Map based on Longitude (generated) and Latitude (generated). Color shows sum of Admissions. Size shows sum of Admissions. Details are shown for Zip Code. The data is filtered on Hospital, which keeps WSH. The view is filtered on sum of Admissions, which ranges from 5 to 150.

Patients originating from each region of the state are demographically similar. Tables 8 and 9 identify the basic patient demographics at Western and Eastern State Hospitals, categorized by civil and forensic designation, respectively. With respect to the civil population, Eastern State Hospital serves a slightly higher proportion of female, geriatric and non-Hispanic white patients than Western State Hospital.

Table 8. Civil State Hospital Population Demographics (CY 2015)

Demographic Type	Western State Hospital		Eastern State Hospital	
	Clients	% of Total	Clients	% of Total
Gender				
Female	376	36%	239	40%
Male	665	64%	362	60%
Age Group				
0-17	-	0%	-	0%
18-64	928	89%	517	86%
65+	113	11%	84	14%
Race/Ethnicity				
Non-Hispanic White	585	56%	394	66%
Minority	456	44%	207	34%

Data Source: DBHR Consumer Information System matched to administrative data from the RDA Client Services Database

When compared to the civil population, the forensic population at both hospitals consists of more male patients, more minority patients and very few geriatric patients.

Table 9. Forensic State Hospital Population Demographics (CY 2015)

Demographic Type	Western State Hospital		Eastern State Hospital	
	Clients	% of Total	Clients	% of Total
Gender				
Female	194	20%	34	15%
Male	787	80%	196	85%
Age Group				
0-17	-	0%	-	0%
18-64	937	96%	217	94%
65+	44	4%	13	6%
Race/Ethnicity				
Non-Hispanic White	458	47%	131	57%
Minority	523	53%	99	43%

Data Source: DBHR Consumer Information System matched to administrative data from the RDA Client Services Database

As an early step in the admission process, patients are classified by bed type. If a bed is available in that classification, the patient will be admitted. If the hospital is operating at capacity for that bed, the patient will likely be placed on a hospital waitlist. Patient bed types are categorized as:

- Civil Beds
 - adult psychiatric: patients age 18-50
 - geropsychiatric: adult patients over the age of 50¹⁸
 - habilitative mental health: patients with developmental or intellectual disabilities

¹⁸ Geropsychiatric categorization can vary widely among providers. State hospital sources indicated that 50 years old is their guideline for geropsychiatric. However other providers in the state and national may use more traditional guidelines, such as over 65.

- other/unspecified: additional beds available contingent on appropriate staffing (Eastern State Hospital indicated that these beds may be used for evaluation and treatment as necessary.)
- Forensic Beds¹⁹
 - forensic evaluation: psychological evaluation to determine competency to stand trial
 - competency restoration: treatment intended to restore competency so that the individual may return to the criminal justice system
 - Not Guilty by Reason of Insanity (NGRI): court-rendered decision wherein the patient is treated for a period of time not to exceed the sentence that would have been applicable for the offense

To understand the relative need for each bed type, Table 10 provides current facility statistics for Washington's two state hospitals. In addition to occupancy rates, the table also presents the average length of stay for patients in each bed. The combination of these two statistics, combined with waitlist data, begin to illustrate the demand for admission and potential reasons for admission delay.

Both Eastern and Western State Hospitals currently operate above 80 percent capacity for civil and forensic beds. Prevailing guidelines suggest that hospitals aim to achieve a maximum 85 percent occupancy rate, although recent literature suggests that occupancy below 85 percent may foster a safer psychiatric treatment milieu.²⁰ Both Eastern and Western State Hospitals experience lower occupancy rates among their competency restoration beds when compared to NGRI beds. Opening of the Maple Lane and Yakima facilities may have diverted a portion of the competency restoration patients away from the state hospitals. Patients in need of competency restoration services represent 38 and 42 percent of the average forensic census for Eastern and Western State Hospitals, respectively, with an average length of stay of approximately two months. Individuals found not guilty by reason of insanity (NGRI) compose the majority of forensic patients for both hospitals, at nearly 60 percent of the forensic population. These patients remain in Western State Hospital an average of three years. For Western State Hospital, the NGRI population presents an ongoing capacity strain, operating at 100 percent occupancy. Eastern State Hospital shows an average length of stay for NGRI patients of 78 months, nearly twice that of Western State Hospital, though the occupancy rate is significantly lower at 84 percent.

For the civil population, occupancy rates for both hospitals are higher across most categories. For Eastern State Hospital, habilitative mental health and adult (non-geriatric) psychiatric needs present the highest strain against the current bed count. These patients represent 60 percent of the average civil census and all but two beds were occupied as of September 2016. For Western State Hospital, adult psychiatric and geropsychiatric beds operate at 98 percent occupancy and represent 95 percent of the average civil census.

With the exception of habilitative mental health, the average civil patient remains in the facility for less than one year per admission. Although representing a smaller portion of the total population, average length of stay for habilitative mental health patients is nearly twice that of other civil patients at Western State Hospital. Eastern State Hospital average length of stay across all civil beds is significantly lower than Western State Hospital. Stakeholders identified the lack of housing and resources for developmentally and intellectually

¹⁹ The list of forensic beds is limited to specific bed types at the state hospital. Jail-based and personal recognizance evaluations are not included here, though they may result in inpatient evaluations or admissions for competency restoration.

²⁰ Teitelbaum, A. et al. 2016. Overcrowding in Psychiatric Wards is Associated with Increased Risk of Adverse Incidents. *Med Care*. 54(3):296-302

disabled individuals as a key barrier to discharge, among other issues related to availability of community services. Such issues are discussed in Section 4.6.

Note that the average lengths of stay for each bed type are based on the bed type from which the patient was discharged. Therefore, the lengths of stay included in the average for a bed type may include days that the patient spent in another bed type.

Table 10. State Hospital Bed Statistics

Bed Type		Eastern State Hospital				Western State Hospital			
		Bed Count	Average Daily Census	Occupancy Rate	Average Length of Stay (months)	Bed Count	Average Daily Census	Occupancy Rate	Average Length of Stay (months)
Forensic Beds	Competency Restoration*	49	39	80%	1.97	124	114	92%	2.07
	Forensic Evaluation	6	5	80%	1.97	7	6	92%	2.07
	NGRI**	70	59	84%	78.62	154	154	100%	39.44
	Total Forensic	125	103	83%	45.74	285	274	96%	23.00
Civil Beds	Habilitative Mental Health	10	10	100%	12.71	30	29	97%	22.45
	Adult Psychiatric	91	89	97%	3.13	414	407	98%	11.38
	Geropsychiatric	91	66	73%	3.86	113	110	98%	11.99
	Total Civil	192	165	86%	4.01	557	547	98%	12.09
Hospital Total		317	268	85%	4.39	842	821	98%	15.73

*Conditional release bed counts are combined with the Competency restoration bed counts for Western State Hospital.

**Not Guilty by Reason of Insanity (NGRI) for Western State Hospital is composed of NGRI-only and NGRI + Competency Restoration bed types. In Eastern State Hospital, NGRI is composed of NGRI-only and NGRI + Conditional Release bed types.

Eastern State Hospital Data Source: OTB Solutions, Updated September 2016

Western State Hospital Data Source: OTB Solutions, Updated July 2016

As noted in Section 4.3, Maple Lane and Yakima exclusively provide competency restoration services for forensic patients. Comparing this bed category in Table 10 to the statistics for Maple Lane and Yakima in Table 11, the new facilities show a decline in average length of stay by roughly 50 percent over the state hospitals. Overall utilization remains low for both satellite facilities, which may be partially attributed to start-up issues experienced at each site.

Table 11. Yakima and Maple Lane Bed Statistics (March 2016 to July 2016)

Facility	Average Admissions Per Month	Average Discharges Per Month	Bed Count	Average Daily Census	Occupancy Rate	Average Length of Stay (months)
Yakima	5.80	2.80	24	7	29%	1.37
Maple Lane	11.20	8.25	30	13.25	44%	1.12

Data Source: Decision Support and Evaluation Office, Behavioral Health Administration.

“Forensic flips” or “felony flips” are individuals who have had their felony charges dismissed because they have been found incompetent by the criminal court. A flip can occur if the individual: (1) has received multiple rounds of restoration services and is determined “not restorable”; or (2) the parties and court have agreed that the person is not restorable and, therefore, have dismissed the charges without completing multiple restoration

periods.²¹ In such instances, the charges are dismissed without prejudice and the individual may be placed in the state hospital for a civil commitment evaluation. The statute does not provide a specific timeframe for the person to be transported to the state hospital following dismissal of the charges, but State staff have indicated that the hospitals aim to transport patients as quickly as possible, generally within seven days or less. Once the patient is admitted to the state hospital, s/he must be evaluated within 72 hours for purposes of filing a civil commitment petition. If a petition is not filed, the hospital must notify the prosecutor of its intent not to file a petition. If a petition is filed, a hearing must be held within ten days. At the hearing, a court will determine whether the individual meets criteria for civil commitment and, if so, an order for up to 180 days will be entered if the grounds for commitment include the felony grounds.²²

Each hospital experiences month over month fluctuation in the number of new flips that occur, as illustrated in Table 12 below. The ratio of forensic flips to total civil beds at each hospital is nearly identical at 0.015:1.

Table 12. Number of Forensic Flips by State Hospital

Fiscal Year 2015	Western State Hospital		Eastern State Hospital	
	Newly Flipped*	Total Flips**	Newly Flipped*	Total Flips**
July	8	113	2	25
August	14	119	1	20
September	3	113	1	21
October	6	113	5	20
November	5	116	2	20
December	4	116	6	24
January	4	111	3	24
February	10	117	2	18
March	10	120	4	21
April	15	128	3	22
May	8	128	6	26
June	9	129	4	27
Average/Month	8	119	3	22

*Newly flipped refers to an individual who is newly flipped from Forensic to Civil at the beginning of a given month

**Total flip includes newly flipped

Data Source: DBHR Consumer Information System

The occupancy rates presented in Table 10 are compounded by the unmet demand for inpatient placements, as shown in Table 13 below. Western State Hospital, with occupancy rates nearing 100 percent for civil populations, shows an average wait time of 25 to 50 days for adult and geriatric civil beds, respectively. The number of adult psychiatric patients waiting for treatment at Western State Hospital represents roughly 20 percent of their total capacity for this population. Conversely, Eastern State Hospital patients experience an average wait time of less than 8 days. Importantly, this data is limited to formal hospital waitlist data and does not account for patients in need of hospitalization who have been unable to access the system entirely.

Recent focus on reducing wait times for the forensic population is also demonstrated in Table 13. For this population, the wait for treatment in Western State Hospital is three times lower than civil adult psychiatric patients.

²¹ See RCW 10.77.086(1)(c) and (4).

²² See RCW 71.05.280(3); See also Detention of R.H., 316 P.3d 535 (2013).

Table 13. Average Number of People on Waitlist for State Hospital

Bed Type	Western State Hospital			Eastern State Hospital		
	# of People	Average Days on Waitlist	Median Days on Waitlist	# of People	Average Days on Waitlist	Median Days on Waitlist
Adult Psychiatric*	47	24.91	15	12	7.30	7
Geropsychiatric**	24	50.75	40.5	4	4.25	4.5
Forensic***	29	7.52	8	5	4.80	4

*WSH PTRC-Central tends to have the general adult population at WSH. Central includes APU, GPU, and E&T Units

**WSH PTRC-East tends to include geropsychiatric and TBI populations, but there are several general adult wards. East includes APU, GPU, and E&T Units

***Forensic includes competency evaluation, not guilty by reason of insanity and forensic evaluation

Data Source: State hospital internal records. WSH waitlist is a snapshot of the waitlist on 7/29/2016. ESH is a snapshot on 8/15/2016.

Treatment and Recovery

Once admitted to the state hospital, a treatment plan will be developed for the patient that may include any variety of the state hospital services listed in Appendix C. These services range from direct care programs, such as individual psychotherapy and cognitive and dialectical behavioral therapy, to medical services and psychosocial programs, such as art therapy and vocational rehabilitation.

Hospital staffing represents a critical factor influencing the level of programming and on-unit care provided. For Western State Hospital, the ratio of permanent direct care staff per patient bed is approximately 1.5, meaning for every patient bed, there are 1.5 full time equivalent, direct care staff members.²³ For Eastern State Hospital, this ratio is approximately 1.8 staff per patient bed, a 17 percent difference overall. Note that these staffing ratios include both permanent staff assigned to specific care units and staff who provide or direct programming across the hospital. The remainder of this section will focus on specific differences in direct care unit staffing.

Eastern and Western State Hospitals staff their forensic and civil beds using a three-shift core unit staffing model. The hospitals use a similar provider mix, with professional treatment staff during the day and nursing and support staff operating evening and night shifts. Shifts overlap by 15 minute increments, allowing for staff briefings between shifts, as scheduled below:

- Day: 6:45AM to 3:00PM
- Evening: 2:45PM to 11:00PM
- Night: 10:45PM to 7:00AM

Appendix D provides the complete staffing complement for both state hospitals, delineated by full-time and part-time positions. Western State Hospital is operating with a vacancy rate of 14.3 percent, while Eastern State Hospital has a vacancy of 8.6 percent. The data presented here represents OTB Solutions' most recent data. As discussed in Section 6.2, OTB Solutions is currently examining the state hospital staffing structure to identify challenges and propose options for improvement. The remainder of this section focuses on current clinical unit staffing by bed type in each state hospital. Vacant positions are not included in the tables below.

Tables 14 and 15 present the forensic staffing at Eastern and Western State Hospitals by bed type. When comparing the average of all shifts, the forensic staff to bed ratio for Eastern State Hospital is nearly identical

²³ The designation of "permanent, direct care" was provided by the hospital directly. Staff positions include clinicians, nursing, therapy, aides, and other individuals directly providing care and treatment for patients. This category does not include administration or other leadership positions.

to Western State Hospital, as indicated at the bottom of Table 15. More significant differences between the two hospitals exist when comparing shifts. Day shifts include professional treatment staff largely responsible for evaluations and mental health programming. Western State Hospital staffs the forensic day shift at a staff to bed ratio roughly 10 percent higher than Eastern State Hospital.

Table 14. Eastern State Hospital Full Time Equivalent Staffing by Forensic Bed Type

Shift	Direct Care Position	Number of Staff by Bed Type		
		Competency Restoration	NGRI	Inpatient Forensic Evaluation
Day	Register Nurse 3	1.78	2.00	0.22
	Registered Nurse 2	6.24	6.30	0.76
	Licensed Practical Nurse	1.78	4.00	0.22
	Mental Health Technician/Nursing Asst.	15.15	12.80	1.85
	Psychiatrist	0.89	2.00	0.11
	Physician	0.89	0.00	0.11
	Psychologist	0.00	1.00	0.00
	Adv. Registered Nurse Practitioner	0.89	1.00	0.11
	Psychology Associate	0.89	0.00	0.11
	Social Worker	2.67	3.00	0.33
	Total Day Shift Direct Care Staff	31.18	32.10	3.82
	Direct Care Staff per Bed	0.64	0.46	0.67
	Evening	Registered Nurse 3	1.78	2.00
Registered Nurse 2		4.45	4.70	0.55
Licensed Practical Nurse		2.67	3.00	0.33
Mental Health Technician/Nursing Asst.		13.36	13.10	1.64
Total Evening Shift Direct Care Staff		22.27	22.80	2.73
Direct Care Staff per Bed		0.45	0.33	0.45
Night	Registered Nurse 3	1.78	2.00	0.22
	Registered Nurse 2	3.56	5.30	0.44
	Licensed Practical Nurse	1.78	3.00	0.22
	Mental Health Technician/Nursing Asst.	8.02	11.80	0.98
	Total Night Shift Direct Care Staff	15.15	22.10	1.85
	Direct Care Staff per Bed	0.31	0.32	0.31
All	Total Direct Care Staff	68.60	77.00	8.40
	Direct Care Staff per Bed	1.40	1.10	1.40

Data Source: OTB Solutions based on July 2016 staffing matrix

Evening staffing for forensic beds is similar in both hospitals in terms of total direct care staff. However, the Eastern State Hospital model favors mental health technicians whereas Western State Hospital favors licensed practical nurses. For the night shift, Eastern State Hospital employs a staff to bed ratio approximately 18 percent higher than Western State Hospital across all forensic bed types.

Table 15. Western State Hospital Full Time Equivalent Staffing by Forensic Bed Type

Shift	Direct Care Position	Competency Restoration	NGRI	Inpatient Forensic Evaluation
Day	Register Nurse 3	4.73	5.00	0.27
	Registered Nurse 2	16.09	14.00	0.91
	Licensed Practical Nurse	13.25	15.00	0.75
	Mental Health Technician/Nursing Asst.	24.61	25.00	1.39
	Institution Counselor 2	1.89	0.00	0.11
	Psychiatrist	7.57	5.50	0.43
	Physician	1.97	2.41	0.11
	Psychologist	4.73	5.00	0.27
	Social Worker	10.41	8.00	0.59
	Total Day Shift Direct Care Staff	85.27	79.91	4.81
	Direct Care Staff per Bed	0.69	0.52	0.69
	Delta from Eastern State Hospital	0.05	0.06	0.02
Evening	Register Nurse 3	4.26	3.50	0.24
	Registered Nurse 2	13.25	14.00	0.75
	Licensed Practical Nurse	13.25	14.00	0.75
	Mental Health Technician/Nursing Asst.	24.61	24.00	1.39
	Total Evening Shift Direct Care Staff	55.37	55.50	3.13
	Direct Care Staff per Bed	0.45	0.36	0.45
	Delta from Eastern State Hospital	0.00	0.03	0.00
Night	Register Nurse 3	3.31	2.50	0.19
	Registered Nurse 2	7.57	10.00	0.43
	Licensed Practical Nurse	11.36	11.00	0.64
	Mental Health Technician/Nursing Asst.	13.25	15.00	0.75
	Total Evening Shift Direct Care Staff	35.50	38.50	2.00
	Direct Care Staff per Bed	0.29	0.25	0.29
	Delta from Eastern State Hospital	-0.02	-0.07	-0.02
All	Total Direct Care Staff	176.14	173.91	9.94
	Direct Care Staff per Bed	1.42	1.13	1.42
	Delta from Eastern State Hospital	0.02	0.03	0.02

Data Source: OTB Solutions based on July 2016 staffing matrix

Tables 16 and 17 present civil bed staffing at the state hospitals by bed type. Overall, Eastern State Hospital operates a staff to civil bed ratio approximately 16 percent higher than Western State Hospital. As shown in Table 17, Eastern State Hospital nearly doubles the number of staff at Western State Hospital for habilitative beds. This difference persists across all shifts.

Table 16. Eastern State Hospital Full Time Equivalent Staffing by Civil Bed Type

Shift	Direct Care Position	Habilitative Mental Health	Adult Psychiatric	Geropsychiatric
Day	Register Nurse 3	1.00	3.00	3.00
	Registered Nurse 2	2.00	8.00	10.20
	Licensed Practical Nurse	1.00	8.00	5.00
	Mental Health Technician/Nursing Asst.	8.00	21.00	21.00
	Psychiatrist	0.50	4.00	4.00
	Physician	1.00	1.00	0.00
	Psychologist	0.00	4.00	2.00
	Adv. Registered Nurse Practitioner	0.00	1.00	2.00
	Social Worker	1.00	6.00	5.00
	Total Day Shift Direct Care Staff	14.50	56.00	52.20
	Direct Care Staff per Bed	1.45	0.62	0.57
Evening	Register Nurse 3	1.00	3.00	3.00
	Registered Nurse 2	2.00	10.50	8.50
	Licensed Practical Nurse	0.00	4.00	4.00
	Mental Health Technician/Nursing Asst.	11.00	29.00	19.50
	Total Evening Shift Direct Care Staff	14.00	46.50	35.00
	Direct Care Staff per Bed	1.40	0.51	0.38
Night	Register Nurse 3	1.00	3.00	3.00
	Registered Nurse 2	2.00	8.00	6.00
	Licensed Practical Nurse	1.00	4.00	3.00
	Mental Health Technician/Nursing Asst.	8.00	12.00	11.00
	Total Night Shift Direct Care Staff	12.00	27.00	23.00
Direct Care Staff per Bed	1.20	0.30	0.25	
All	Total Direct Care Staff	40.50	129.50	110.20
	Direct Care Staff per Bed	4.05	1.42	1.21

Data Source: OTB Solutions based on July 2016 staffing matrix

As noted for the forensic beds, evening and night shift staffing for Western State Hospital similarly favors the use of licensed practical nurses whereas Eastern State Hospital more heavily relies on mental health technicians.

Table 17. Western State Hospital Full Time Equivalent Staffing by Civil Bed Type

Shift	Direct Care Position	Habilitative Mental Health	Adult Psychiatric*	Geropsychiatric**
Day	Register Nurse 3	1.00	14.00	4.00
	Registered Nurse 2	2.00	38.00	12.00
	Licensed Practical Nurse	3.00	43.00	14.00
	Mental Health Technician/Nursing Asst.	0.00	64.00	22.00
	Institution Counselor 2	12.00	10.00	0.00
	Institution Counselor 3	4.00	1.00	0.00
	Psychiatrist	1.00	14.00	5.00
	Physician	0.66	7.31	3.33
	Psychologist	0.00	14.00	4.00
	Social Worker	1.00	11.50	6.50
	Total Day Shift Direct Care Staff	24.66	216.81	70.83
	Direct Care Staff per Bed	0.82	0.52	0.63
		Delta from Eastern State Hospital	-0.63	-0.10
Evening	Register Nurse 3	1.00	8.50	2.50
	Registered Nurse 2	1.00	37.00	12.00
	Licensed Practical Nurse	2.00	41.00	12.00
	Mental Health Technician/Nursing Asst.	3.00	61.00	20.00
	Institution Counselor 2	14.00	7.00	0.00
	Institution Counselor 3	2.00	1.00	0.00
	Total Evening Shift Direct Care Staff	23.00	155.50	46.50
	Direct Care Staff per Bed	0.77	0.38	0.41
	Delta from Eastern State Hospital	-0.63	-0.13	0.03
Night	Register Nurse 3	1.00	8.00	2.00
	Registered Nurse 2	2.00	28.00	8.00
	Licensed Practical Nurse	3.00	38.00	10.00
	Mental Health Technician/Nursing Asst.	1.00	44.00	14.00
	Institution Counselor 2	7.00	0.00	0.00
	Total Night Shift Direct Care Staff	14.00	118.00	34.00
	Direct Care Staff per Bed	0.47	0.29	0.30
	Delta from Eastern State Hospital	-0.73	-0.01	0.05
All	Total Direct Care Staff	61.66	490.31	151.33
	Direct Care Staff per Bed	2.06	1.18	1.34
	Delta from Eastern State Hospital	-1.99	-0.24	0.13

Data Source: OTB Solutions based on July 2016 staffing matrix

Discharge

When a patient's care team has determined that the patient is ready to safely continue treatment in the community, the hospital will coordinate with community providers and BHO staff to process the patient's discharge. For patients found not guilty by reason of insanity, this process includes two significant transition steps. First, the patient must successfully demonstrate that they can manage grounds privileges, with ongoing

treatment, housing and monitoring at the hospital. Second, the patient must successfully manage conditional release, in which the patient continues treatment and monitoring, but resides outside of the hospital.

Tables 18 and 19 show the primary diagnoses at discharge from Western and Eastern State Hospitals, respectively, by bed type. Adult psychiatric patients are more likely to be discharged with schizophrenia and other psychotic disorders. Although these disorders are also the most common among geropsychiatric discharges, 11 percent of the geropsychiatric population at Western State Hospital have a primary diagnosis of dementia.²⁴ Dementia can present challenges for appropriate placement and will be discussed later in this section. Western State Hospital forensic patients discharged from competency restoration represent a range of diagnoses, with a small portion (10 percent) of the population showing substance use disorder as the primary diagnosis. Eastern State Hospital reports diagnoses differently. However, cognitive disorders at Eastern State Hospital likely include dementia and compose 14 percent of the geropsychiatric population. Eastern State Hospital does not independently report substance use disorders, and thus cannot be compared directly to Western State Hospital.

Table 18. Primary Diagnosis at Discharge from Western State Hospital, SFY 2015

Diagnosis Type	Adult Psychiatric	Competency Restoration (Forensic)	Geropsychiatric	Habilitative Mental Health	NGRI and other Forensic
Schizophrenic Disorders	299	232	49	<10	<10
Other Psychoses	14	147	<10	0	<10
Episodic Mood Disorders	59	111	16	<10	<10
Substance Use Disorders	<10	62	<10	0	<10
Anxiety and Other Mood Disorders	<10	24	<10	0	<10
Sexual Dysfunctions	<10	22	<10	<10	0
Observation for Suspected Mental Condition	<10	11	0	0	0
Major Neurocognitive Disorders	0	<10	<10	0	0
OCD, other or unspecified disorder due to medical condition	0	<10	<10	<10	<10
Person Seeking Consultation	0	<10	0	0	0
Personal History of Mental Disorder	<10	<10	<10	0	0
Substance induced or related disorders	<10	<10	0	0	<10
Autism Spectrum	0	0	0	<10	0
Other	0	0	<10	<10	0
Other Dementias	<10	0	11	0	0
Total	385	632	98	11	16

Data Source: State hospital discharge records submitted to DBHR by each hospital.

²⁴ Note: The Aging and Long Term Support Administration has indicated that many patients discharged from the state hospital with a diagnosis of dementia also have a diagnosis of schizophrenia or other severe and persistent mental illness that predated dementia.

Table 19. Primary Diagnosis at Discharge from Eastern State Hospital, Calendar Year 2015

Diagnosis Type	Adult Psychiatric	Competency Restoration (Forensic)	Geropsychiatric	Habilitative Mental Health	NGRI and other Forensic
Schizophrenia or Other Psychotic Disorders	171	40	107	<10	<10
Mood Disorders	109	19	66	<10	<10
Cognitive Disorders	<10	<10	31	0	<10
Adjustment Disorders	0	<10	<10	0	0
Anxiety Disorders	<10	<10	<10	0	0
No Diagnosis on Axis I (II)	<10	11	<10	0	0
Diagnosis Deferred on Axis I (II)	<10	<10	0	0	0
Impulse Control Disorders	<10	0	0	<10	0
Other	<10	<10	0	0	0
Personality Disorders	<10	14	0	0	0
Total	308	95	210	<10	<10

Data Source: State hospital discharge records submitted to DBHR by each hospital.

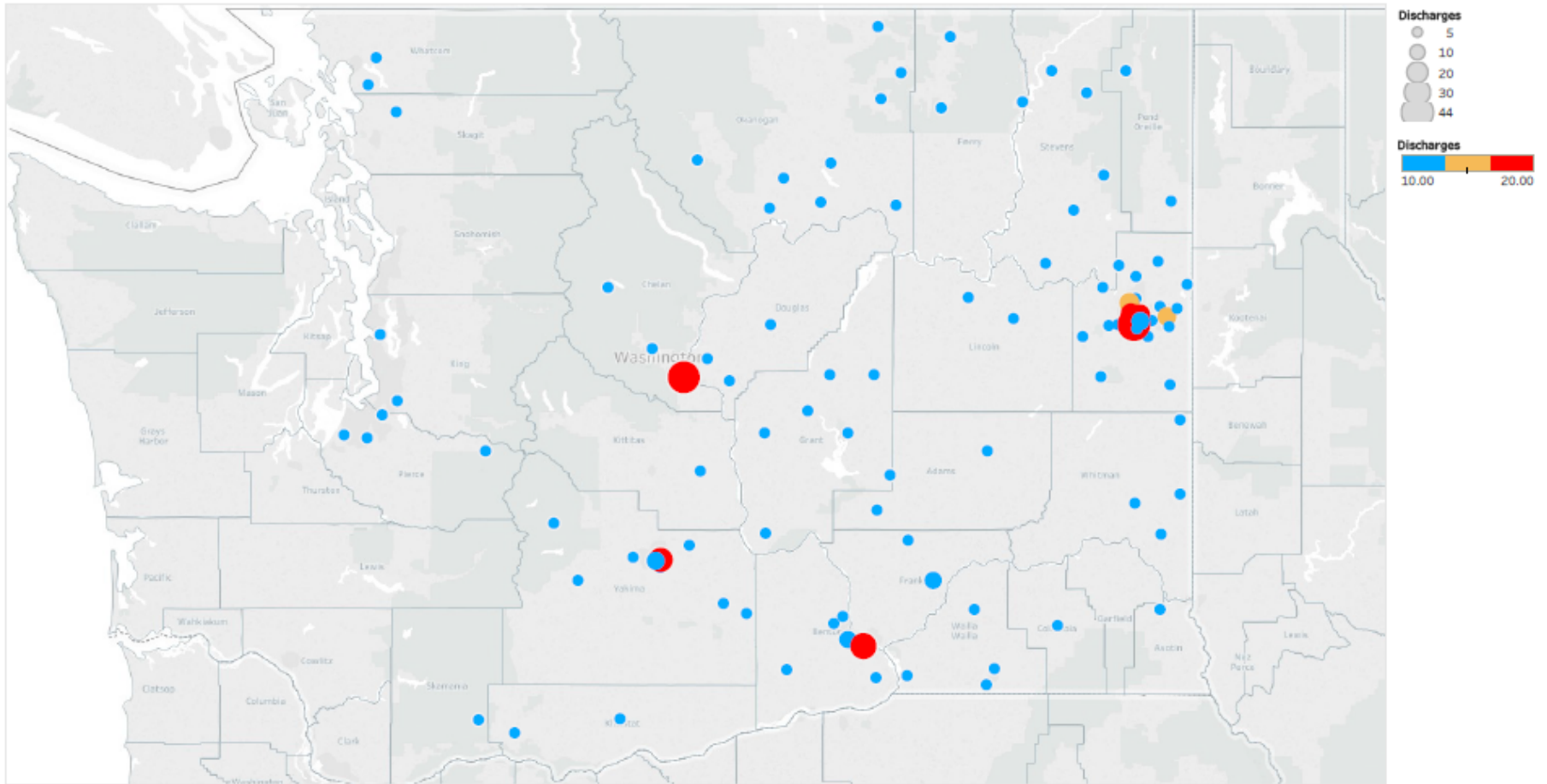
For patients with dementia or other diagnoses that require specialized residential care, the patient's discharge placement will be based on the availability of beds closest to the patient's preferred community. In general, when patients are discharged back to the community, they are typically placed in geographic areas similar to the areas of highest admission concentration.

Figures 5 and 6 show the zip code to which the majority of patients are discharged.²⁵ For Eastern State Hospital, the top three areas for discharge are in Spokane, Wenatchee and Kennewick. An examination of the raw discharge data shows that Wenatchee has one sixth the population of Spokane but one third the discharge frequency. For Western State Hospital, the top three areas for discharge are in Seattle, Tacoma and Everett. While having only one sixth of the population of Seattle, Everett experiences one quarter the discharge frequency.

²⁵ Discharge zip code is collected by the state hospitals and reported to DBHR. In cases where the discharge zip code was either unknown or blank, CSDB data were used to account for missing values.

Figure 5. Eastern State Hospital Discharges by Zip Code

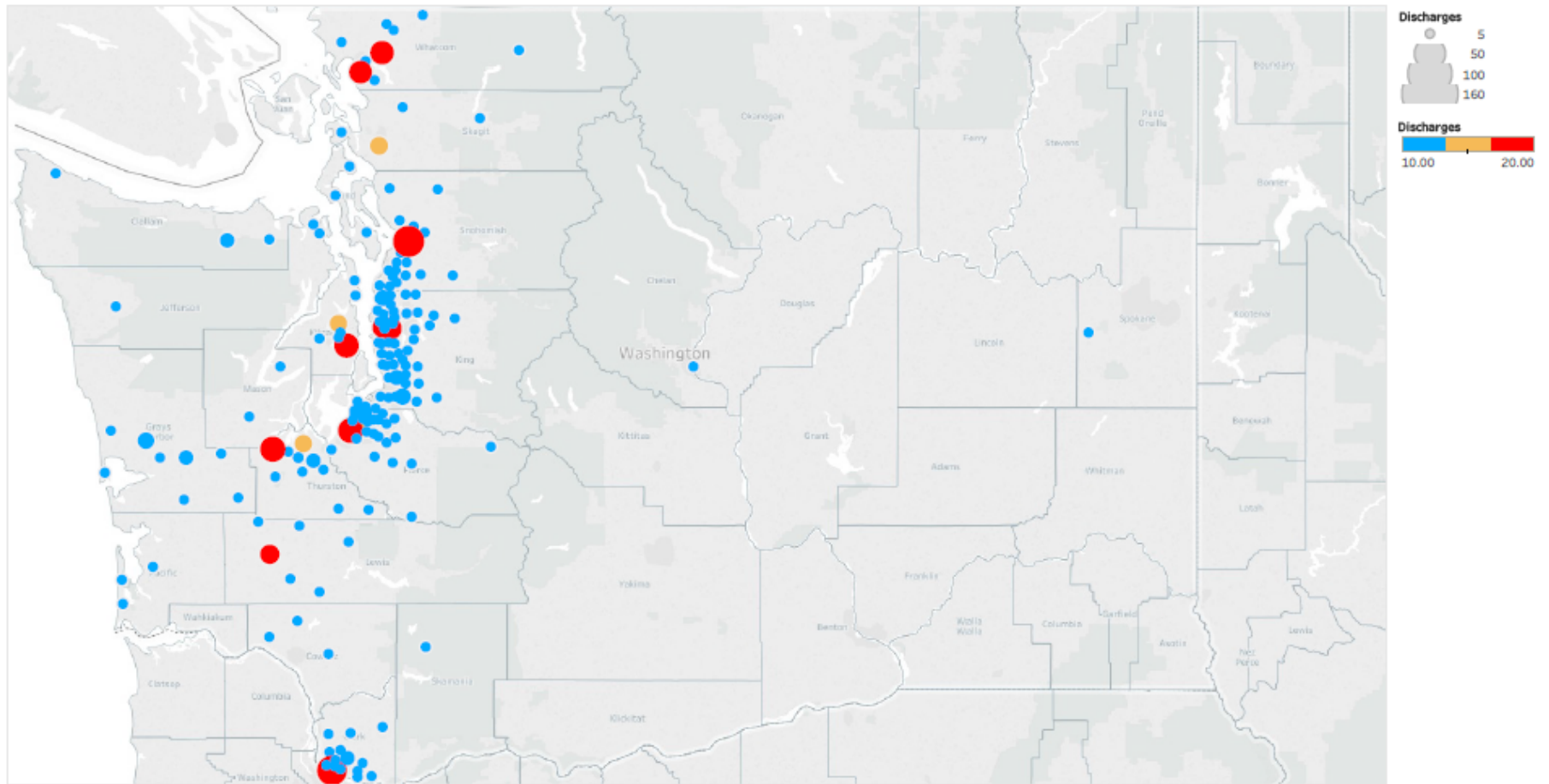
Eastern State Hospital Discharges by Zip Code



Map based on Longitude (generated) and Latitude (generated). Color shows sum of Discharges. Size shows sum of Discharges. Details are shown for Zip Code. The data is filtered on Hospital, which keeps ESH. The view is filtered on sum of Discharges, which ranges from 5 to 50.

Figure 6. Western State Hospital Discharges by Zip Code

Western State Hospital Discharges by Zip Code



Map based on Longitude (generated) and Latitude (generated). Color shows sum of Discharges. Size shows sum of Discharges. Details are shown for Zip Code. The data is filtered on Hospital, which keeps WSH. The view is filtered on sum of Discharges, which ranges from 5 to 50.

Once a patient has been discharged, a portion of those patients are likely to return to the state hospital setting within 30 days. Table 20 shows the average 30-day readmission rates for Western and Eastern State Hospitals. As discussed further in Section 4.6, readmission rates for state hospitals in Washington are significantly lower than the national average, which in 2014 was approximately 8 percent.²⁶

Table 20. 30-Day Readmission Rates by State Hospital, Calendar Year 2015

	Western State Hospital	Eastern State Hospital
	30-day readmission rate	30-day readmission rate
Annual Average (%)	3.60	4.10

Data Source: Division of Behavioral Health and Recovery, Consumer Information System

4.6. Transition Planning and Challenges

Successfully supporting a patient as they re-enter the community from an inpatient setting requires extensive planning, ideally beginning at admission and following the patient after discharge. When a BHO patient is discharged from a community hospital or evaluation and treatment center into the community, shorter lengths of stay and seamless funding may help minimize the number of challenges that patients and their providers face during this time. This section will focus mainly on the transition planning process and potential barriers encountered for patients transitioning from state hospitalization.

Transition Planning

Both Eastern and Western State Hospitals have extensive written procedures documenting how civil transitions from the hospital to the community should work.²⁷ A complex set of hospital staff may be involved in this process. Western State Hospital has approximately 55 staff in ten position classifications who are involved in transitions. Eastern State Hospital has at least 30 staff, not including nurses, who are also spread across multiple position descriptions. While the primary position involved in transition planning is the psychiatric social worker, other staff play critical roles in successful planning, such as:

- psychologists who make the determination that the hospital should file for a 180 commitment order or a least restrictive alternative order
- pharmacists to supervise medication instructions and training
- physical therapists, if needed
- a financial benefits coordinator who may initiate applications for Social Security, Medicaid or other benefits
- a community nurse who may be involved in structured placements such as nursing homes or adult family homes

The primary responsibility for transition planning at the state hospital falls on the psychiatric social workers. These individuals:

- Work with the individual and their family or guardian regarding the discharge plan.

²⁶ Washington 2014 Mental Health National Outcome Measures: SAMHSA Uniform Reporting System

²⁷ The focus in this section is on the complexities of civil transitions. At the completion of competency restoration, forensic individuals are generally released back to the charging jurisdiction/jail.

- Identify financial resources and refer for state and federal benefits.
- Refer for substance use evaluations and other behavioral health treatment needed.
- Assess the need for community supports such as home health services or assisted living programs.
- Coordinate with the BHO liaison and other behavioral health agency staff.

Each state hospital has entered into an agreement with the BHOs. Under this agreement, the BHO liaison staff or discharge coordinators have the primary responsibility for ensuring appropriate placement for individuals who are civilly committed. In stakeholder interviews, BHO liaison staff generally reported strong relationships with the hospitals psychiatric social workers. The work of the hospital psychiatric social worker and the BHO staff may overlap in overcoming discharge obstacles, such as obtaining a birth certificate so an individual can apply for benefits or contacting potential placements. BHO staff do not directly provide case management to individuals being released. The responsibility for any case management provided lies with the BHO contracted provider who provides services after hospital discharge.

Generally, after discharge, the person is transitioned to outpatient mental health services and does not remain on the liaison caseload. If the individual is released under a less restrictive order, they must be monitored by a mental health professional and the BHO must provide the less restrictive treatment required in the order.

Before an individual is discharged, an appropriate placement must be secured. For some individuals, this placement could be their own home or the home of a caregiver. While affordable housing is a problem for many individuals and families, this issue is magnified for individuals with more complex needs. In addition to significant behavior supports, these individuals may require medical treatments and therapies, substance use disorder treatment, assistance with activities of daily living or assistance with habilitation. Residential placements for these individuals can present significant barriers to timely discharge as the residential facility must ensure they can meet the health and safety needs of the patient as well as the other residents to whom they provide care. Stakeholders repeatedly noted that this type of care presents particular issues for the state's most vulnerable patients. The remainder of this section will review such obstacles.

Barriers to Discharge

Based on stakeholder conversations, data analysis and a review of multiple reports on the Washington behavioral health system (See Appendix B), barriers to discharge from the state hospitals are a well-known and frequently discussed topic.

As noted above, the primary barrier to discharge identified by previous reports and by stakeholders interviewed for this analysis is a lack of residential care with services for individuals with complex needs. Individuals with complex needs typically have a serious mental illness compounded by dementia, behavior issues, intellectual or developmental disabilities, ongoing medical problems, odious criminal history or substance abuse issues. They may also include individuals who are high utilizers of mental health services absent other complexities. Specific strategies to reduce discharge barriers will vary depending on which of these issues are prevalent.

In addition to residential care with appropriate support services, discussions with stakeholders and analysis of the data presented in this section revealed the following challenges:

- low provider reimbursement rates for certain types of patients
- absence of a standardized assessment for discharge readiness across units in the hospitals

- absence of electronic medical record keeping systems and data discharge systems in the hospitals
- difficulty filling psychiatric workforce positions
- difficulty obtaining guardianship
- barriers specific to homelessness and serious mental illness
- processes for individuals who refuse to leave the hospital setting
- ambiguity regarding service availability in the community

The subsection will begin with a discussion of residential care availability and associated data and then revisit the additional challenges identified above.

Availability of Specialized Residential Care

Two state agencies are primarily responsible for administering residential care programs for populations who are not intellectually or developed disabled: (1) the Aging and Long-Term Support Administration (AL TSA); and (2) the Division of Behavioral Health and Recovery (DBHR), through its contracts with the BHO. Note that, as discussed throughout this section, while AL TSA represents a primary administrator of residential services, their facilities were not intended to provide the breadth of behavioral and social supports required of many state hospital patients.

AL TSA staff report that 32 people have moved from Western State Hospital to AL TSA funded settings from April 1, 2016 to August 31, 2016. Eleven additional people who received assessments or coordination of services reportedly moved from Western State Hospital to settings not funded by AL TSA. At least 20 people discharged from local psychiatric hospital beds have moved to AL TSA funded services instead of moving to Western State Hospital. In 2016, a total of 85 patients from Eastern State Hospital were assisted by AL TSA to relocate to community based settings.

By regulation, AL TSA does not provide mental health services. The provision of mental health services occurs under the federal 1915(b) waiver that establishes requirements of the BHOs. However, an examination of discharge lists at the state hospitals show there is an expectation that the residential programs sponsored by AL TSA and the BHOs are both potential destinations for persons leaving the state hospitals. A discharge “wait list” dated July 14, 2016 was provided for Western State Hospital, which identifies the number of civil patients awaiting discharge, the main barrier to their discharge and the type of housing each patient requires. Of the 174 civil patients awaiting discharge, “lack of appropriate housing available” is cited as the discharge barrier for 120 (69 percent) of patients. All other barriers to discharge were cited ten or fewer times and are identified in the list of additional barriers above.

As shown in Table 21, of the 174 civil patients, 92 require some level of assistance with activities of daily living (ADLs) in addition to on-going mental health services.²⁸ The settings where individuals can receive assistance with ADLs include the individual’s own home or a family member’s home (with family or paid professionals providing care) or a licensed residential service that provides an alternative to nursing home care, such as an Adult Family Home (AFH), Assisted Living Facility (ALF) or Skilled Nursing Facility (SNF). An additional

²⁸ Data provided directly by the Office of Financial Management for Western State Hospital. AL TSA has indicated that the number of patients included in this category is 45.

55 civil patients require supported living placement, such as in a group home or State Operated Living Alternative.

Table 21. Type of Housing Needed for Civil Patients Awaiting Discharge at Western State Hospital

Types of Housing Needed	Number of Civil Patients
Long Term Care	92
Supported Living	55
Independent	27
Total Civil Patients Awaiting Discharge	174

Data Source: Data file from Office of Financial Management "201607-PRR-909-WSH-Final Redacted Wait List"

As the scope of services provided by residential facilities is directly impacted by Medicaid regulations and sub-regulations, below is a brief description of the purpose and scope of care provided by the majority of the licensed residential settings serving Department of Social and Health Services clients with functional disabilities. Home and community based services are largely optional Medicaid authorities that states may elect to provide through either the Medicaid State Plan or through a variety of federal home and community based waivers. These authorities allow states to develop services available in the community that provide an alternative to institutional settings. Adult Family Homes and Assisted Living Facilities are settings developed as alternatives to skilled nursing facilities and therefore, as mandated under federal rule, the functional eligibility for those programs is identical to the eligibility to receive nursing facility care. Medicaid services provided in those settings are designed to provide the same type of services needed by residents of skilled nursing facilities. These services are largely focused on providing assistance with unmet needs for activities of daily living such as bathing, medication assistance, ambulation, transfers, eating, etc. The level of assistance with these services may include hands-on care or cueing and supervision. These authorities also pay for nurse delegation and home health services not covered under the state's Medicaid Plan.

Eligibility for these services requires both financial and functional eligibility determination and the functional eligibility for these services is determined using a standardized assessment called the Comprehensive Assessment Reporting Evaluation (CARE) tool. Through the assessment, a client is placed in one of 17 classifications depending on clinical characteristics, such as unmet need for assistance with activities of daily living and factors that impact the time it takes to assist with ADLs, such as clinical complexity, mood and behavior and level of cognitive functioning. Payment under the state's long term care Medicaid authorities is tied to those classification groups. CARE is not intended to assess the level of unmet need for mental health or substance use disorder use, but does contain screening questions that identify the need for referral to state and community entities that assess unmet need and provide those types of services.

There is also an exception to rule process in WAC 388-440-0001 used by ALTSA in cases where a client's need differs from the majority and additional payment is justified to meet the client's personal care needs. As required under WAC, exceptions to rule are determined based on an individualized review of the client's assessed need for personal care services. Existing record keeping systems do not distinguish the reasons exceptions were granted. Across the long-term care system, exceptional personal care rates are less than 4 percent of all authorizations.

Over the past decade, the long-term care system has developed additional services and supports designed to address the behavioral support needs of patients relocating or diverting from psychiatric hospital settings into

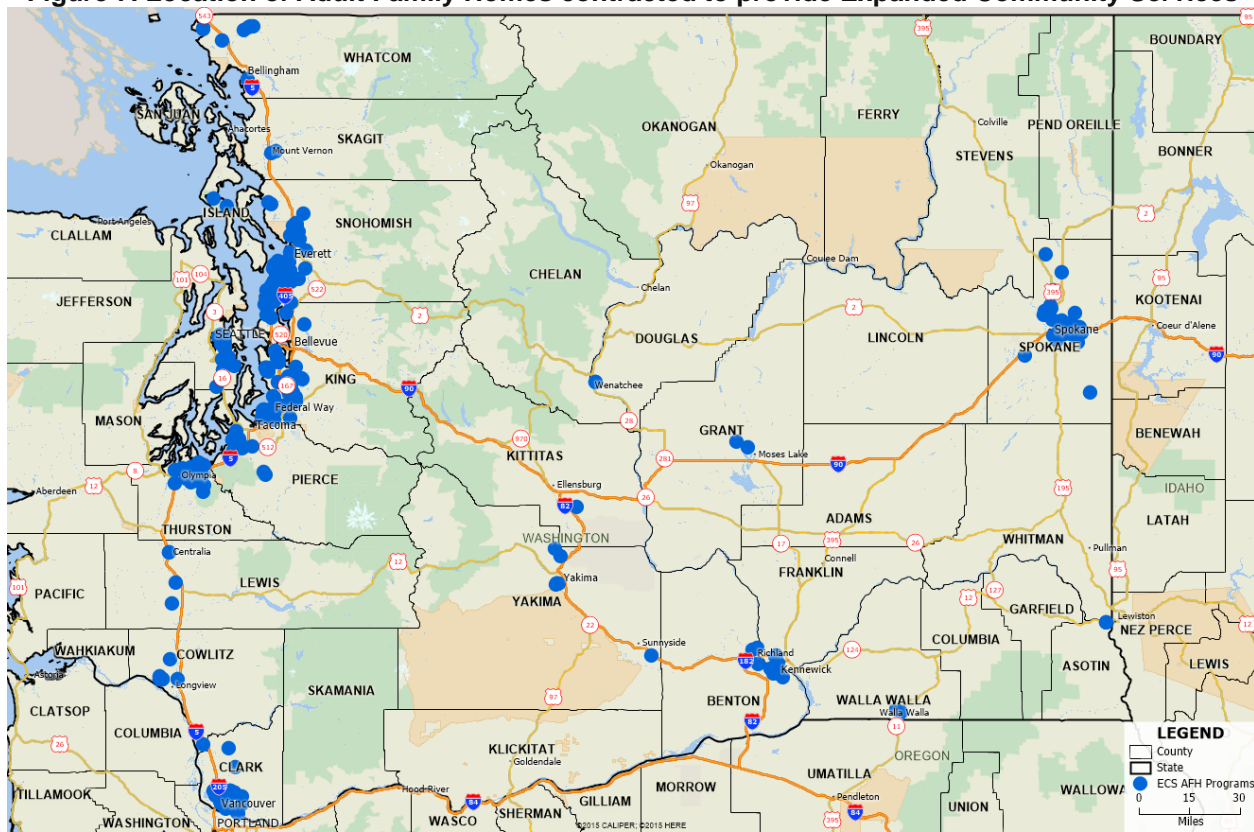
settings funded by ALTSA. These services do not include mental health treatments or therapies as those services are provided through the BHOs. ALTSA services provide behavioral support specialists who design individualized behavioral support plans used by the patient and their providers to reduce intensity and frequency of behaviors. These services intend to maintain the residential placement and improve the quality of life for the patient. These services also provide additional staffing support for the residential provider to implement the behavioral support plans funded through an enhanced daily rate to the residential provider. The behavioral support services are provided through contracted community providers, typically mental health centers.

The ALTSA residential programs discussed below were originally developed to aid individuals with long-term care needs, not behavioral health needs. These facilities typically do not have the expertise to serve individuals relocating from psychiatric hospital settings. ALTSA, having developed a large residential service system over the past several decades, has indicated that it is in the process of retrofitting a portion of the system to accommodate the lack of residential services for persons with behavioral health needs.

Expanded Community Services (ECSs) are available to clients relocating or diverting from state psychiatric hospitals served in Adult Family Homes (AFHs), Assisted Living Facilities (ALFs) and Skilled Nursing Facilities (SNFs). Under ALTSA auspices, about 700 individuals have received ECS services this year including 100 moving from state hospitals onto ECS. These homes are concentrated in areas where clients most frequently discharge. ECS contracts are available in every DSHS region and every BHO region, though not in every county. Figure 7 shows the locations of these facilities. As of September 2016, DSHS data indicate that 275 AFHs with approximately 1,550 beds were contracted to offer expanded community services.²⁹ They are concentrated near urban areas, are close to freeways and are not generally available in less populated areas, such as the middle and northern parts of the state. Approximately 20 of these programs are located between Spokane and Seattle.

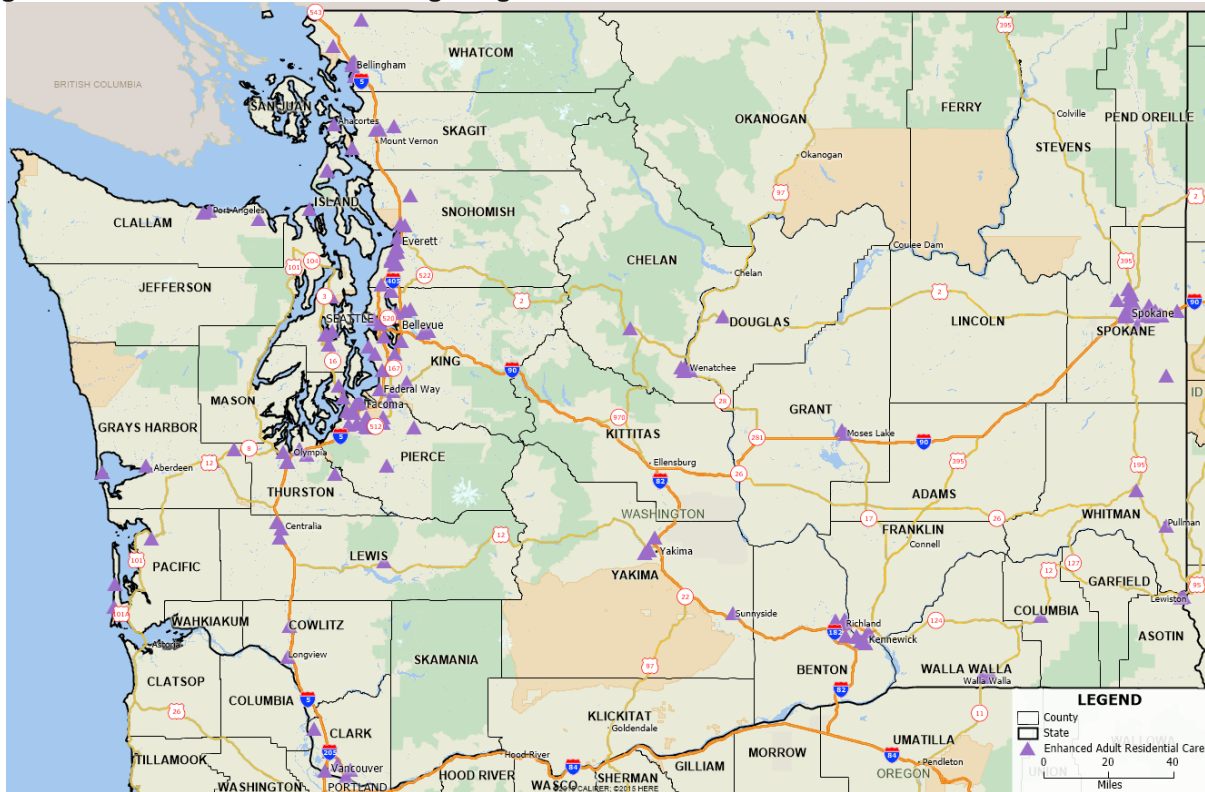
²⁹ Data on expanded community services retrieved on 9-23-2016 from <https://fortress.wa.gov/dshs/adsaapps/lookup/AFHAdvLookup.aspx>. Figure 7 does not include Skilled Nursing Facilities or Assisted Living Programs that are contracted to provide ECS services.

Figure 7. Location of Adult Family Homes contracted to provide Expanded Community Services



The Enhanced Adult Residential Care program is another AL TSA program that potentially serves persons with more complex needs. As of August 2016, approximately 160 programs containing about 10,000 beds were contracted to provide enhanced adult residential care and a map of their locations is shown in Figure 8. Again, programs are clustered in Spokane and Seattle and along U.S. Interstate 5.³⁰

³⁰ Data on enhanced adult residential care retrieved from <https://fortress.wa.gov/dshs/adsaapps/Lookup/BHAdvLookup.aspx>

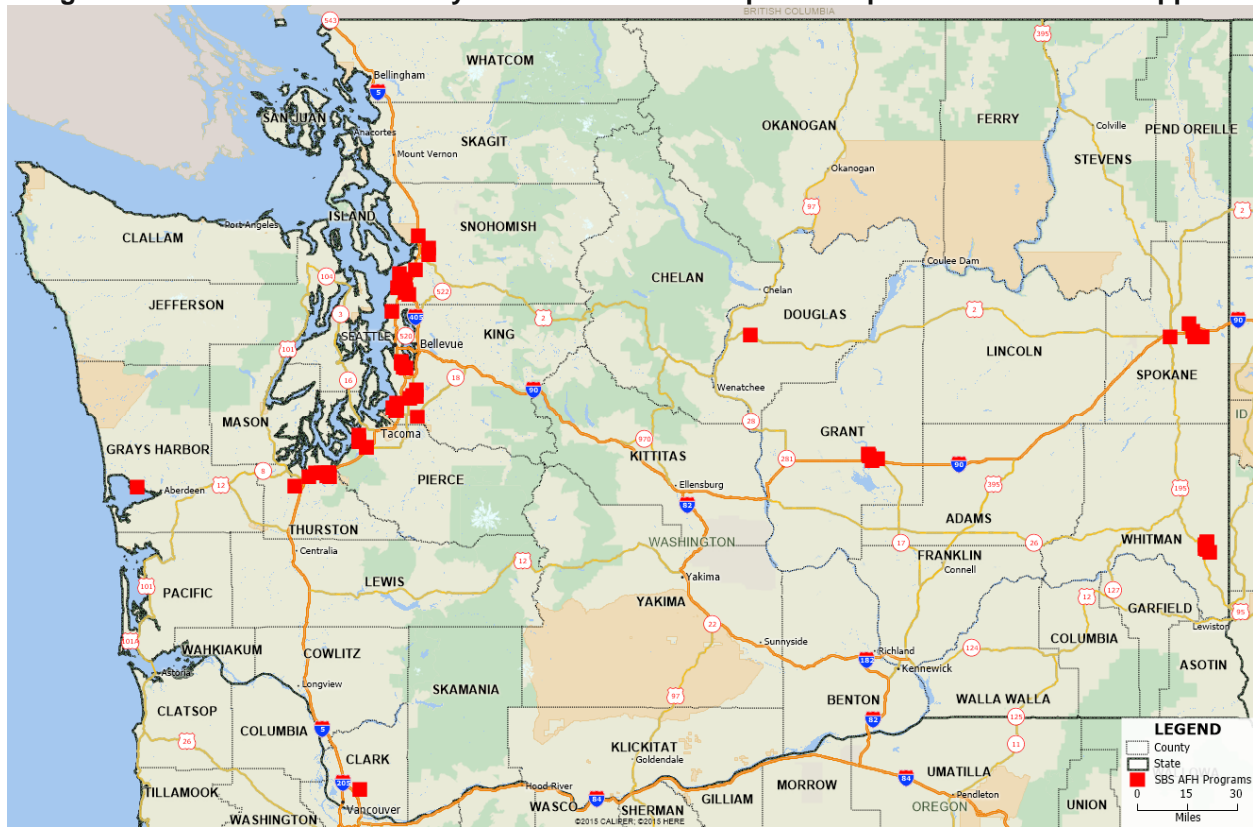
Figure 8. Location of Assisted Living Programs contracted for Enhanced Adult Residential Care

Specialized Dementia Care programs are also available for residents in ALFs. Licensing records indicate that 60 ALFs operating roughly 3,550 beds are contracted to provide specialized dementia care. These providers/services have been developed to relocate and divert individuals from nursing facilities. These facilities typically do not have the expertise to serve individuals relocating from psychiatric hospital settings.

Authorized at Chapter 70.97 RCW, state funds were used to build two Enhanced Services Facilities. These facilities are designed to care for individuals with a high level of need who ordinarily would not be served via other community programs. One of these programs operates eight beds in the Spokane Valley area and the other is planned for Vancouver with 12 beds. The Vancouver facility is anticipated to open in September 2016 at the writing of this report.

Specialized Behavior Support programs are available in AFHs and Enhanced Service Facilities. There are approximately 65 adult family homes that offer specialized behavior support and a map of their locations is shown in Figure 9.³¹ They are primarily found along Puget Sound and in Spokane and are not generally available in most parts of the state.

³¹ Data on specialized behavior support retrieved from <https://fortress.wa.gov/dshs/adsaapps/Lookup/AFHAdvLookup.aspx>

Figure 9. Location of Adult Family Homes contracted to provide Specialized Behavior Support

As noted above, the BHOs have funding available for residential placements to aid state hospital discharges. The BHOs contract with approximately 140 group homes and supported living programs. Licensing data indicates that some of these contracted facilities are licensed as adult family homes or assisted living programs and others include agencies providing supported living services to individuals with intellectual and developmental disabilities. The BHOs also contract with approximately 20 residential providers for 545 beds. State staff have indicated that these beds are generally filled. Information on the amount of expenditures on these programs or the extent to which BHOs make other supplemental payments to adult foster homes or assisted living programs is not available.

The Division of Behavioral Health and Recovery (DBHR) offers multiple programs with residential services. In fiscal year 2015-16, approximately \$2.4 million was budgeted for Access to Recovery services, which included transitional housing.³² The Housing and Recovery through Peer Services (HARPS) program served approximately 1,000 persons in fiscal year 2014-15 and funded three peer support teams to help persons with their housing needs. Priority populations served by HARPS include persons discharged from psychiatric and substance abuse inpatient facilities.³³

There are two smaller projects relevant to housing, the Projects for Assistance in Transition from Homelessness (PATH) and the Permanent Options for Recovery-Centered Housing (PORCH) Program.

³² Retrieved on 9-24-2016. See fact sheet at <https://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/Fact%20Sheets/Access%20to%20Recovery%204.pdf>

³³ Retrieved on 9-24-2016. See fact sheet at https://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/Fact%20Sheets/Housing_Recovery_Peer_Services.pdf

Discussions with stakeholders indicate that these are smaller programs and are not used for the relief of state hospital discharge barriers. PATH is the larger of the two programs. In fiscal year 2014-15, it served about 4,100 persons of whom about 900 were also receiving community mental health services. The PATH budget was \$1.3 million. An examination of 2013-14 RSN financial reports found only two RSNs had a PORCH program and its fiscal year 2015-16 funding was only \$300,000.³⁴

DBHR also served approximately 9,000 adults in substance abuse residential programs in fiscal year 2014-15 through both long and short-term residential programs at a cost of roughly \$21 million.³⁵

Low Provider Reimbursement Rates for Certain Types of Patients

Low state reimbursement rates for services provided in residential settings continue to be identified by state staff and other stakeholders as barriers to discharge.

The CARE system of assessment is used nationally to determine the appropriate level of care and reimbursement for patients seeking long-term services. Patients in the state hospital who have high, Medicaid relevant ADL needs typically score high on the CARE assessment, and providers would receive higher reimbursement rates for these individuals. These rates may be supplemented by the use of a behavioral support service to help the provider implement the individual's care plan.

A patient in the state hospital who does not have high ADL needs, conversely, may not score high on the CARE assessment and may not meet a Medicaid nursing home level of eligibility. In these situations, the patient may not be eligible for Medicaid home and community-based services and the state would receive no federal matching funds should the person be placed in a home and community-based setting. The Medicaid rate in such instances may be low or non-existent. Though not meeting specific placement criteria, such patients may present with medical needs and significant behavioral problems, making their placement in a community setting more difficult.

Placing this individual in a residential setting presents a multi-agency challenge. State hospital staff, DBHR and the BHOs share responsibility in identifying and transitioning patients to appropriate behavioral health service providers, which, as discussed above, may or may not also include AL TSA. Comments by stakeholders and document reviews point to slower discharges when multiple agencies are involved. Stakeholders indicated that the state does not currently have a systematic strategy to incentivize available facilities to accept low-income, high-need patients.

Civil Discharge Readiness Assessments

The concept of a discharge “wait list” may best be approached with conceptual caution. There is no standardized definition of when a person is “ready to be discharged” since these decisions are made by the medical leadership of each of the 19 civil units of the hospital.³⁶ The two state hospitals also show significant differences in their discharge lists, according to state staff. In addition, the discharge list may change frequently

³⁴ Retrieved on 9-24-2016. See fact sheet at <https://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/Fact%20Sheets/PORCH%202015-2016.pdf>

³⁵ Retrieved on 9-24-2016. See fact sheet at <https://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/Fact%20Sheets/Treatment%20for%20SUD%20-%20Residential.pdf>

³⁶ State documentation uses the words “ward” and “unit” interchangeably. The units typically have 29-31 beds and contain persons with similar characteristics. For example, hospital documents describe unit E5 at Western as a “30 bed coed admission unit for patients 50+ years old who have psychiatric and/or cognitive disorders.”

due to day to day changes in the patient's status. Rather than employing a single discharge policy, the protocol used depends on the medical leadership in the units. Consistency across units has not been documented. Stakeholders interviewed in different regions of the state provided examples of patients who were determined "ready to discharge" in one unit, but saw that determination reversed when moved to a different unit.

The wait list often contains short one-paragraph descriptions of the person's current circumstances. These descriptions document the variability in discharge readiness should an opportunity materialize.³⁷ Sometimes readiness means two months and other times two weeks. Stakeholders further commented on a lack of understanding regarding how patients are categorized and processed for discharge. This situation was discussed in the 2009 Geller report on state hospitals (cited in Appendix B) and still exists today.

Ambiguity with respect to discharge readiness has negative results, creating issues for the liaison staff of community providers who link with the hospital to begin patient intake. Lack of standardization has raised suspicion among some stakeholders that there are instances when hospital staff will not release a patient for personal, rather than medical, reasons. Although not confirmed by data, it is clear that ambiguity in discharge readiness may lead to delays in placing patients.³⁸

Electronic Medical Records and Data Processing

The BHOs, Medicaid staff and state hospitals do not use a common electronic health record system or case management system. Lack of uniformity likely creates additional unnecessary inefficiencies. For example, discharge packets are faxed to potential providers instead of being electronically sent, adding to the administrative workload in accepting new patients and leaving room for discrepancies in how patient information is documented. The development of an electronic health record for individuals at the hospitals would likely improve the speed and efficiency of discharges, as well as communications among Medicaid and BHO staff. Strong communication is especially important in situations where staff from multiple agencies need to coordinate activities.

Psychiatric Workforce

The difficulty of filling psychiatric workforce positions was also a frequently mentioned barrier by stakeholders. For all 1,412 full-time permanent positions, Western State Hospital operates at a vacancy rate of 14.2 percent. Of its 268 non-permanent direct care positions, the vacancy rate was 20 percent. Table 22 shows the top five vacancy rates of permanent staff at Western State Hospital.

³⁷ These same comments apply to the "discharge list: of approximately 35 names obtained from Eastern State Hospital

³⁸ The focus of this discussion is on civil discharge barriers given the report's intended purposes. However, there are a number of reports on forensic services provided in Washington such as

http://app.leg.wa.gov/ReportsToTheLegislature/Home/GetPDF?fileName=SSB%205732%20Forensic%20Mental%20Health%20-%20Consultant%20Review%208-1-14_f0bf65c7-0048-489f-be25-6e01c89be4a0.pdf

Table 22. Permanent Staff Position Titles at Western State with the Five Highest Vacancy Rates

Position Title	Actual Positions in Job Class	Vacant Positions	% Vacancy
Physician 3	18	3	16.7%
Licensed Practical Nurse 2/4	170	29	17.1%
Psychologist 3/4	33	7	21.2%
Psychiatric Security Nurse	80	23	28.8%
Recreation Therapist 2	10	3	30.0%
Registered Nurse 2	230	69	30.0%

Data Source: OTB solutions, updated July 2016

Eastern State Hospital operates at a vacancy rate of 10 percent across 823 full-time permanent positions. Table 23 shows the top five vacancy rates of permanent direct care staff at Eastern State Hospital.

Table 23. Permanent Staff Position Titles at Eastern State with the Five Highest Vacancy Rates

Position Title	Actual Positions in Job Class	Vacant Positions	% Vacancy
Recreation Therapist 2	18	3	16.7%
Licensed Practical Nurse 2/4	29	5	17.2%
Psychiatrist	15	3	20.0%
Clinical Nurse Specialist	5	1	20.0%
Psychiatric Security Nurse	16	7	43.8%

Data Source: OTB solutions, updated July 2016

Note the similarities in the types of providers showing the largest vacancy rates. Positions in high demand, such as direct care nursing staff and mental health professionals, play a critical role in determining when a patient is ready for discharge and where they may be appropriately placed. Additional concerns related to workforce development are discussed in detail in Section 6 of this report.

Guardianship

Obtaining guardianship can also cause significant delay. Review of the one-paragraph descriptions of individuals on the discharge lists would indicate that this factor only affects a small number of people, but when guardianship is needed there are two types of delays. One, finding a guardian can be difficult if guardianship agencies decline to accept the referral. Two, guardianship hearings and assessments can take months to schedule.

Homelessness and Serious Mental Illness

Individuals who are homeless and have serious mental illness present other discharge barriers. State Department of Commerce data indicate the state has made significant expenditures to help homeless individuals. Through multiple housing projects, such as the Housing Trust Fund, the number of homeless

families receiving assistance has doubled from 9,400 in calendar year 2009 to 18,800 in calendar year 2014.³⁹ Despite these efforts, BHO staff who discussed this barrier noted that landlords and potential housing providers are reluctant to accept individuals who are mentally ill.

Patients Who Refuse to Leave the Hospital

Capsule descriptions on the state hospital discharge lists also contain references to patients who refuse to leave the hospital. Transitions can be extremely stressful for patients, to the point where they believe staying in the hospital is a better alternative. There are no apparent agreements between the BHOs and hospitals to structure discharges for individuals who refuse to participate in discharge planning or refuse reasonable placements.

Ambiguity in Service Availability

As discussed in Section 4.2, the complete array of services available in the state is both large and disparately organized among various programs and funding streams. Stakeholders repeatedly stressed that individuals working in different parts of the mental health system are not fully aware of all of the services and providers who are available in the patient's community. A lack of standardized tracking and reporting practices across the system was cited as a key issue in addition to the workforce development and provider reimbursement challenges.

4.7. Funding the System

As noted throughout the continuum of care discussed in Sections 1.2 through 1.6 of this report, funding plays a key role in determining how successfully a patient can navigate through the system. This section discusses current mental health spending in Washington, sources of funding and how that funding is distributed among the various parts of the system.

To establish context for analysis of the revenue streams of specific mental health provider types, this section first provides data regarding overall mental health spending in Washington. Table 24 provides total mental health spending in the state from 2007-2017. Spending has risen substantially during the time period, increasing 75 percent. The fastest growing portion is federal funds, which grew from \$253 million to \$613 million over the decade, an increase of 142 percent. Federal funds increased significantly in state fiscal year 2015 reflecting the expansion of Medicaid under the Affordable Care Act. In contrast to the high rate of growth in federal spending, state general funds increased 35 per cent over the same ten-year period.

³⁹ Data obtained from the Department of Social and Health Services. File name is "Homeless Capital". It is not known how many were DSHS mental health clients.

Table 24. Mental Health Spending in Washington 2007-2017

State Fiscal Year	General Fund-State	General Fund-Federal	General Fund-Local	Other Funds	Total
FY 2007	\$415,255,000	\$252,964,000	\$26,836,000	\$1,058,000	\$696,113,000
FY 2008	\$450,930,000	\$265,034,000	\$41,248,000	\$3,604,000	\$760,816,000
FY 2009	\$429,203,000	\$308,459,000	\$45,830,000	\$3,529,000	\$787,021,000
FY 2010	\$398,968,000	\$334,592,000	\$39,744,000	\$971,000	\$774,275,000
FY 2011	\$388,588,000	\$342,638,000	\$41,996,000	\$2,505,000	\$775,727,000
FY 2012	\$438,381,000	\$303,863,000	\$43,035,000	\$2,548,000	\$787,827,000
FY 2013	\$445,731,000	\$309,601,000	\$40,530,000	\$2,703,000	\$798,565,000
FY 2014	\$473,782,000	\$375,135,000	\$38,638,407	\$0	\$887,555,407
FY 2015	\$483,677,000	\$572,361,247	\$37,970,000	\$983,000	\$1,094,991,247
FY 2016	\$499,964,000	\$583,376,000	\$34,160,400	\$2,778,000	\$1,120,278,400
FY 2017	\$561,723,000	\$612,675,000	\$34,085,000	\$12,464,000	\$1,220,947,000

Data Source: Data provided directly by DSHS, titled "030 Funding FY07-17"

Table 25 presents community mental health services funded through the Regional Support Networks. Total funding increased over time even with several decreases on a year over year basis. Specifically, budget cuts occurred in state fiscal years between 2010 and 2012 despite supplemental federal dollars provided through The American Recovery and Reinvestment Act of 2009 (ARRA) (Pub. L. 111–5).

State General Fund spending was essentially flat for the state fiscal years 2013, 2014 and 2015. It was reduced in 2016 and increased in 2017. During stakeholder interviews, the 2016 decrease was commented on by multiple individuals. While State General Funds fluctuated, the total amount of funding spent on community services increased rapidly due to a substantive increase in federal funds. Total funds have increased from \$550 million in state fiscal year 2013 to \$889 million in projected state fiscal year 2017 appropriations.

Table 25. Funds Spent to Support Community Mental Health Activities

State Fiscal Year	General Fund-State	General Fund-Federal	General Fund-Local	General Fund-Fed ARRA	Hospital Safety Net- State	Dedicated Marijuana-State	Total Funds
FY 2004	\$198,499	\$193,582	-	-	-	-	\$392,081
FY 2005	\$207,775	\$186,545	-	-	-	-	\$394,320
FY 2006	\$259,620	\$159,246	-	-	-	-	\$418,866
FY 2007	\$273,159	\$163,254	\$5,376	-	-	-	\$441,789
FY 2008	\$300,217	\$171,771	\$6,427	-	-	-	\$478,415
FY 2009	\$313,174	\$206,465	\$8,596	\$24,264	-	-	\$552,499
FY 2010	\$273,950	\$201,169	\$7,743	\$43,539	\$971	-	\$527,372
FY 2011	\$268,887	\$201,019	\$5,874	\$40,955	\$2,505	-	\$519,240
FY 2012	\$316,958	\$212,490	\$9,094	-	\$2,548	-	\$541,090
FY 2013	\$321,411	\$217,500	\$8,770	-	\$2,703	-	\$550,384
FY 2014	\$323,623	\$309,119	\$7,582	-	-	-	\$640,324
FY 2015	\$325,089	\$451,930	\$4,918	-	-	-	\$781,937
FY 2016	\$310,977	\$489,967	\$8,932	-	-	\$2,778	\$812,654
FY 2017	\$355,262	\$521,303	\$8,932	-	-	\$3,684	\$889,181

Data Source: Data provided directly by DSHS, titled "subprogram 1000"

State Hospitals

Table 26 shows the revenue sources used to support operations at Eastern State Hospital. The two primary sources of funding are state general fund dollars and federal disproportionate share funds (DSH). Medicare funds ranged from \$6.5 million to \$9.1 million over the period and were the third largest source of hospital income at Eastern.

Table 26. Revenue Sources for 2012- 2016 at Eastern State Hospital

Eastern Revenues by Source	2012	2013	2014	2015	2016
Federal	\$3,528,264	\$2,945,468	\$4,442,319	\$3,987,042	\$4,811,336
Disproportionate Share - Federal	\$19,419,149	\$19,885,209	\$19,430,368	\$19,712,625	\$19,771,763
Local - Medicare	\$8,347,603	\$8,070,098	\$9,128,823	\$6,570,614	\$7,279,212
Local - Private	\$618,171	\$673,009	\$602,780	\$392,961	\$430,900
Local - Insurance	\$3,333,752	\$3,238,820	\$2,948,536	\$3,023,524	\$3,259,611
General Fund State	\$20,368,060	\$21,533,395	\$24,329,173	\$27,493,235	\$36,891,180
Total Expenditures	\$55,615,000	\$56,346,000	\$60,882,000	\$61,180,000	\$72,444,000

Data Source: Data provided directly by DSHS, titled "Eastern State Hospital Revenue Summary"

Table 27 demonstrates these revenue changes as annual percentage changes. Total expenditures at Eastern State Hospital increased approximately 30 percent over the five-year period. Almost all of the increase was funded by State General Funds. Medicaid funding was close to flat and other income sources declined.

Table 27. Annual Percentage Change in Revenue Sources for 2012- 2016 at Eastern State Hospital

Revenue by Source	2012	2013	2014	2015	2016	2012-2016
Federal	-	-16.5%	50.8%	-10.2%	20.7%	36.4%
Disproportionate Share - Federal	-	2.4%	-2.3%	1.5%	0.3%	1.8%
Local - Medicare	-	-3.3%	13.1%	-28.0%	10.8%	-12.8%
Local - Private	-	8.9%	-10.4%	-34.8%	9.7%	-30.3%
Local - Insurance	-	-2.8%	-9.0%	2.5%	7.8%	-2.2%
General Fund State	-	5.7%	13.0%	13.0%	34.2%	81.1%
Total Expenditures	-	1.3%	8.1%	0.5%	18.4%	30.3%

Data Source: Data supporting this analysis provided by DSHS, titled "Eastern State Hospital Summary"

Table 28 provides the revenue sources used to support operations at Western State Hospital. State General Funds are the largest revenue stream used to support hospital operations followed by federal Medicaid funding under the disproportionate share program (DSH). Medicare is the third largest funding source.

Table 28. Revenue Sources for 2012- 2016 at Western State Hospital

Revenue by Source	2012	2013	2014	2015	2016
Federal	\$2,576,881	\$3,099,840	\$4,402,947	\$4,572,911	\$5,187,010
Disproportionate Share - Federal	\$43,223,267	\$44,260,625	\$45,708,906	\$46,437,125	\$46,576,436
Local - Medicare	\$11,900,730	\$10,273,540	\$12,751,495	\$11,508,182	\$10,171,776
Local - Private	\$2,274,699	\$1,867,704	\$1,716,728	\$1,975,863	\$1,809,937
Local - Insurance	\$4,447,166	\$3,880,193	\$3,158,440	\$3,874,091	\$3,456,357
General Fund State	\$88,485,715	\$93,675,585	\$98,490,276	\$100,695,331	\$119,524,069
Total Expenditures	\$152,908,459	\$157,057,488	\$166,228,791	\$169,063,503	\$186,725,585

Data Source: Data provided directly by DSHS, titled "WSH 5-year Revenue Summary"

Table 29 expresses these revenue changes as annual percentage changes. Total expenditures increased approximately 22 percent over the five-year period. As with Eastern State Hospital, almost all the increase at Western State Hospital was funded by state general funds. Although Medicaid funding doubled, it started small. Other income sources declined.

Table 29. Annual Percentage Change in Revenue Sources for 2012- 2016 at Western State Hospital

Revenue by Source	2012	2013	2014	2015	2016	2012-2016
Federal	-	20.3%	42.0%	3.9%	13.4%	101.3%
Disproportionate Share - Federal	-	2.4%	3.3%	1.6%	0.3%	7.8%
Local - Medicare	-	-13.7%	24.1%	-9.8%	-11.6%	-14.5%
Local - Private	-	-17.9%	-8.1%	15.1%	-8.4%	-20.4%
Local - Insurance	-	-12.7%	-18.6%	22.7%	-10.8%	-22.3%
General Fund State	-	5.9%	5.1%	2.2%	18.7%	35.1%
Total Expenditures	-	2.7%	5.8%	1.7%	10.4%	22.1%

Data Source: Data supporting this analysis provided by DSHS, titled "WSH 5-year Revenue Summary"

Data on types of revenue used to fund forensic bed types and the cost per forensic bed day is not available. The three forensic bed types at state hospitals are:

- beds used for "not guilty by reason of insanity (NGRI)"
- beds used for forensic competency restoration
- beds used for inpatient forensic evaluation

State hospitals do not track revenue by bed type for forensic clients. Forensic clients are intermixed throughout the forensic wards and thus it is difficult for a hospital to point to a specific forensic ward and state the cost of operating the ward. Typically, not guilty by reason of insanity (NGRI) patients are housed in their own ward, but there are occasions when higher functioning forensic patient(s) may share the ward depending on bed availability.

Table 30 contains the direct and allocated indirect costs to operate identified types of beds at the state hospitals.⁴⁰ Cost data shown here was extracted from the state's accounting system, Agency Financial Reporting System.

Table 30. SFY 2015 Direct and Allocated Costs to Operate Types of Beds at State Hospitals

Hospital	Forensic	Civil	Civil DD	Civil Geriatric
Eastern State Hospital	\$20,900,215	\$20,007,691	\$4,567,985	\$18,034,503
Western State Hospital	\$51,288,850	\$72,479,922	\$6,989,110	\$29,210,598

Data Source: Data provided directly by DSHS, titled "Summary for PCG FY15-16 Bed Costs Per Day"

Table 31 compares the State Fiscal Year 2015 cost per bed day for forensic beds with the three types of civil beds. This was calculated by taking the costs allocated by bed type and dividing them by days of service by bed type to arrive at average cost per day for the bed types. The cost per bed day was higher at Eastern State Hospital for all types of beds in this fiscal year. The largest difference was the daily rate for a person with a developmental disability. These are the bed day charges paid by BHOs should they exceed their allocation.

Table 31. Cost per Bed Day at Eastern and Western by Type of Bed

FY 2015	Forensic	Civil	Civil DD	Civil Geriatric
Eastern State Hospital	\$676	\$668	\$1,251	\$720
Western State Hospital	\$523	\$523	\$653	\$574
% Difference	29%	28%	92%	25%

Data Source: Data provided directly by DSHS, titled "Summary for PCG FY15-16 Bed Costs Per Day"

Evaluation and Treatment Centers

Financial information on evaluation and treatment centers was not received in time to be included in this report. Some of the Evaluation and Treatment programs are privately operated and financial information on charges and revenue sources are not routinely reported. However, utilization data by BHO area from the System for Communicating Outcomes, Performance and Evaluation (SCOPE) were available.

Table 32 below shows that utilization of evaluation and treatment centers has expanded over the last three years by approximately 25 percent. The expansion has occurred primarily in Greater Columbia, North Sound

⁴⁰ The costs do not tie back to Total or State General Funds expended by the state hospitals.

and Pierce. This expansion is significant as in prior years such clients were likely held in emergency rooms or general hospital beds while waiting for a treatment placement.

Table 32. Number of Inpatient Days at Evaluation and Treatment Centers

Evaluation and Treatment Centers in BHO Area*	FY-2013 # Serv. Days	FY-2014 # Serv. Days	FY-2015 # Serv. Days	% Change 2013 to 2015
Chelan/ Douglas	0	0	0	0
Grays Harbor	0	0	0	0
Greater Columbia	1,686	3,114	6,345	276%
King	10,774	11,094	11,648	8%
MHD/ Unassigned	0	0	22	
North Sound	80	5,870	4,414	5418%
Peninsula	7,825	8,154	7,708	-1%
Pierce	11,958	11,917	14,597	22%
Southwest BH	2,614	2,710	2,994	15%
Spokane	11,351	11,739	11,328	0%
Thurston/ Mason	5,275	5,509	5,399	2%
Timberlands	0	0	0	0%
Total	51,563	60,107	64,455	25%

* Bed days reported based on E&T location. Chelan-Douglas, Grays Harbor and Timberland show no bed days since they do not have E&T capacity in their regions. Each BHO has agreements with other BHOs for E&T utilization.
Data Source: System for Communicating Outcomes, Performance and Evaluation (SCOPE)

Private, Non-profit Psychiatric Units

Table 33 shows the top four revenue sources for hospital psychiatric units. Medicare and Medicaid compose approximately 72 percent of revenue.⁴¹ The next largest revenue source is commercial insurance composing about 13 percent of total revenues. The fourth largest revenue source is contracted payments which compose a little less than 5 percent of revenues. All other revenue sources including worker's compensation, self-pay and health maintenance organizations compose less than 5 percent of total revenues. Interestingly, three Medicare providers account for about half of all Medicare expenditures and one Medicaid provider accounts for about a third of all Medicaid expenditures.

⁴¹ 2015 Standard Reports in the Comprehensive Hospital Abstract Reporting System (CHARS). See <http://www.doh.wa.gov/DataandStatisticalReports/HealthcareinWashington/HospitalandPatientData/HospitalDischargeDataCHARS/CHARSReports>

Table 33. Major Sources of Revenue for Hospital Psychiatric Units

Psychiatric Units	Medicare	Medicaid	Commercial	Contractors
Cascade Behavioral Hospital	\$19,628,775	\$6,463,500	\$109,200	\$5,173,875
EvergreenHealth Monroe	\$61,371	None	\$246,061	None
Fairfax Behavioral Health Everett	\$2,525,600	\$15,296,400	\$3,595,200	\$1,526,000
Fairfax Behavioral Health Kirkland	\$9,654,400	\$62,431,600	\$19,810,000	\$10,547,600
Lourdes Counseling Center	\$4,239,736	\$6,955,429	\$1,913,075	\$1,466,427
MultiCare Auburn Medical Center	\$47,490,769	\$736,257	\$680,596	\$388,391
Navos	\$8,764,088	\$5,586,543	\$2,419,487	\$539,299
Overlake Medical Center	\$2,545,949	\$2,818,614	\$6,836,492	\$440,873
PeaceHealth Southwest Medical Center	\$3,391,779	\$3,075,829	\$1,382,683	\$389,905
PeaceHealth St. Joseph Medical Center	\$6,675,475	\$8,533,232	\$1,117,569	\$1,277,643
Providence Sacred Heart Medical Center & Children's Hospital	\$11,859,888	\$12,888,056	\$2,769,597	\$1,293,222
Providence St. Peter Hospital	\$5,978,081	\$7,300,584	\$2,000,452	\$1,353,932
Skagit Valley Hospital	\$3,666,637	\$3,565,981	\$128,683	\$1,045,455
Swedish Cherry Hill	\$3,959,043	\$2,082,477	\$7,361,999	None
Swedish Edmonds	\$9,546,314	\$8,772,540	\$7,042,700	None
UW Medicine/Harborview Medical Center	\$20,049,096	\$26,046,212	\$4,455,841	None
UW Medicine/Northwest Hospital & Medical Center	\$27,123,287	\$2,318,759	\$865,819	None
UW Medicine/University of Washington Medical Center	\$2,398,379	\$1,890,507	\$3,741,991	None
Yakima Valley Memorial Hospital	\$4,954,773	\$3,712,066	\$2,364,428	None
Total Dollars	\$194,513,442	\$180,474,584	\$68,841,873	\$25,442,621
Percent of Total Revenue	37.83%	35.10%	13.39%	4.95%

Data Source: 2015 Standard Reports in the Comprehensive Hospital Abstract Reporting System (CHARS)

Table 34 provides the charge per day, the number of patient days billed, the total charges and the mean length of stay for the psychiatric units of the identified community hospitals. One hospital charges less than a \$1,000 a day, two charge between \$1,000 and \$2,000 and the rest charge more than \$2000 a day. The mean average across all hospitals is approximately \$3,000 a day. The units provided 183,000 days of care and the mean length of stay is approximately 12 days.

Table 34. Charge per Day, Patient Days, Total Charges and Mean Length of Stay for Psychiatric Units of Community Hospitals

Community Hospital	Charge per Day	Patient Days	Total Charges	Mean Length of Stay
Cascade Behavioral Hospital	\$1,397	23,548	\$32,908,050	11.14
EvergreenHealth Monroe	\$781	458	\$357,703	9.96
Fairfax Behavioral Health Everett	\$2,800	8,946	\$25,048,800	14.02
Fairfax Behavioral Health Kirkland	\$2,806	44,340	\$124,412,400	9.58
Lourdes Counseling Center	\$2,686	5,437	\$14,604,871	10.16
MultiCare Auburn Medical Center	\$5,527	9,067	\$50,117,684	20.51
Navos	\$1,328	13,980	\$18,564,870	18.18
Overlake Medical Center	\$3,526	4,085	\$14,404,034	4.88
PeaceHealth Southwest Medical Center	\$3,148	2,847	\$8,962,592	9.24
PeaceHealth St. Joseph Medical Center	\$3,375	5,500	\$18,564,632	10.81
Providence Sacred Heart Medical Center & Children's Hospital	\$3,240	10,229	\$33,139,913	9.90
Providence St. Peter Hospital	\$3,288	5,814	\$19,117,707	8.32
Skagit Valley Hospital	\$3,585	2,862	\$10,259,874	8.27
Swedish Cherry Hill	\$3,917	3,568	\$13,976,744	8.45
Swedish Edmonds	\$3,578	7,645	\$27,351,075	14.59
UW Medicine/Harborview Medical Center	\$2,765	18,631	\$51,507,989	16.89
UW Medicine/Northwest Hospital & Medical Center	\$3,368	9,201	\$30,993,368	23.29
UW Medicine/University of Washington	\$2,366	3,680	\$8,706,899	8.78
Yakima Valley Memorial Hospital	\$3,424	3,245	\$11,111,128	11.51

Data Source: 2015 Standard Reports in the Comprehensive Hospital Abstract Reporting System (CHARS)

Note that charges for community hospitals are substantially higher than the daily operating costs at the state hospitals. While not a direct comparison of operating costs, stakeholders indicated that this difference may contribute to utilization of state hospitals for long term stays over community hospital beds.

4.8. Continuum of Care

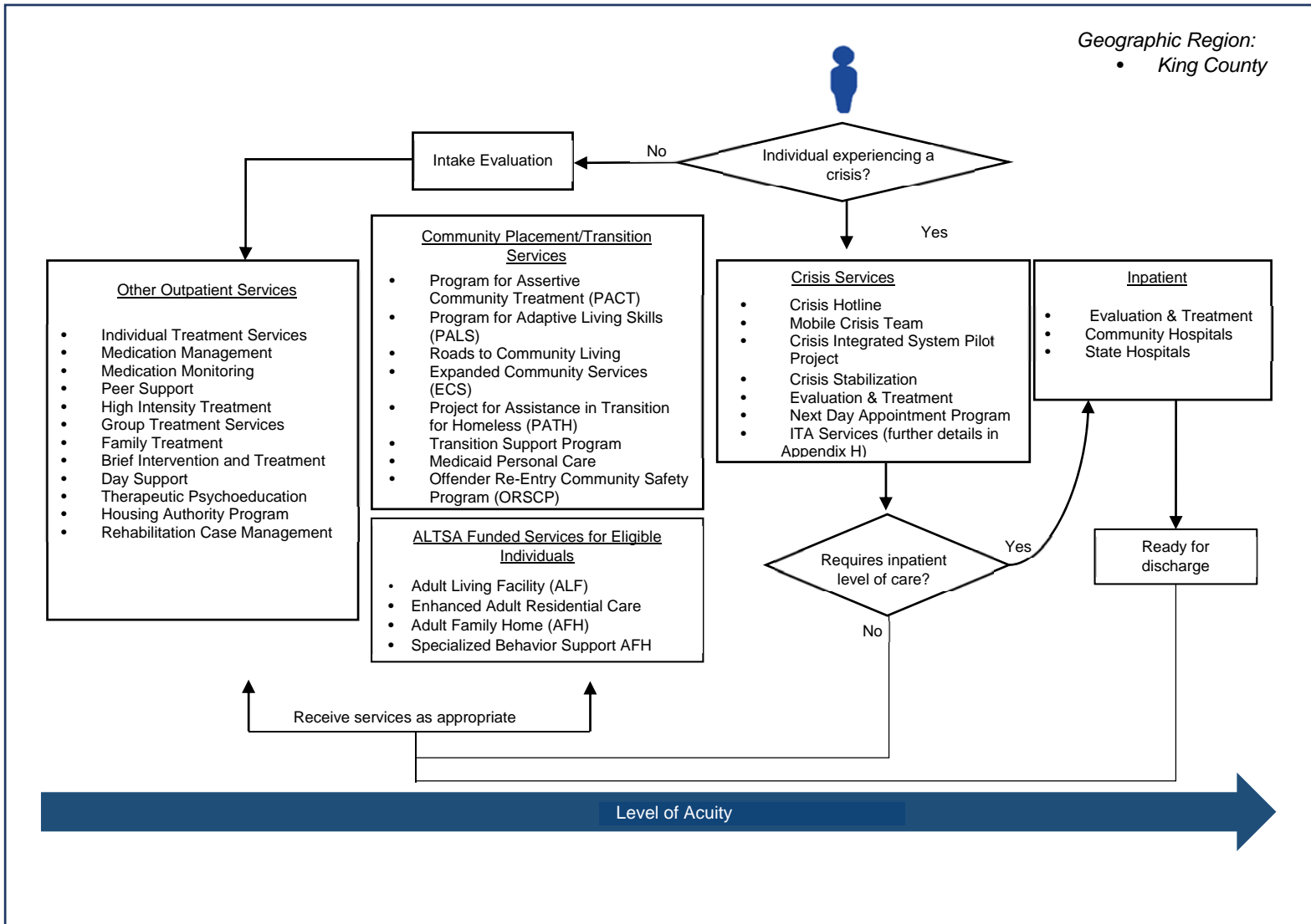
As described in previous sections of this report, there is an array of services available in Washington state that exists external to the state hospitals and evaluation and treatment centers. Services from individualized treatment to peer support programs help individuals to both remain in their community and successfully recover and transition into the community following inpatient hospitalization.

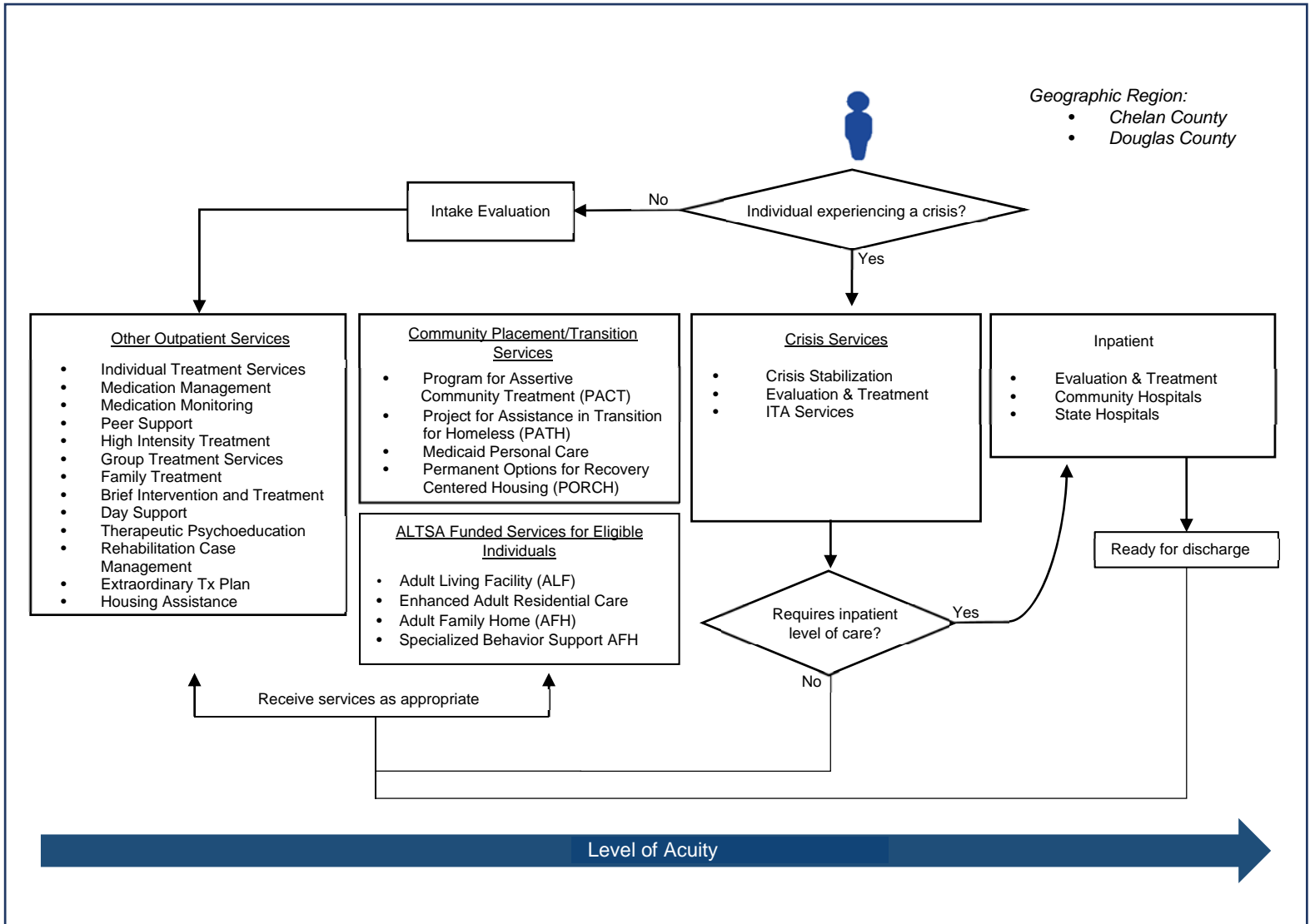
To demonstrate the spectrum of behavioral health services available and the path in which these services are received, this section provides flow charts illustrating services available by geographic region. As noted in Section 4.4, the full range of community resources in the state are disparate due to complexity in funding structures and the broader mental health system. The mapping of services should be read with an understanding that data limitations exist. The following paragraph describes data sources used to determine services provided in the different geographic regions.

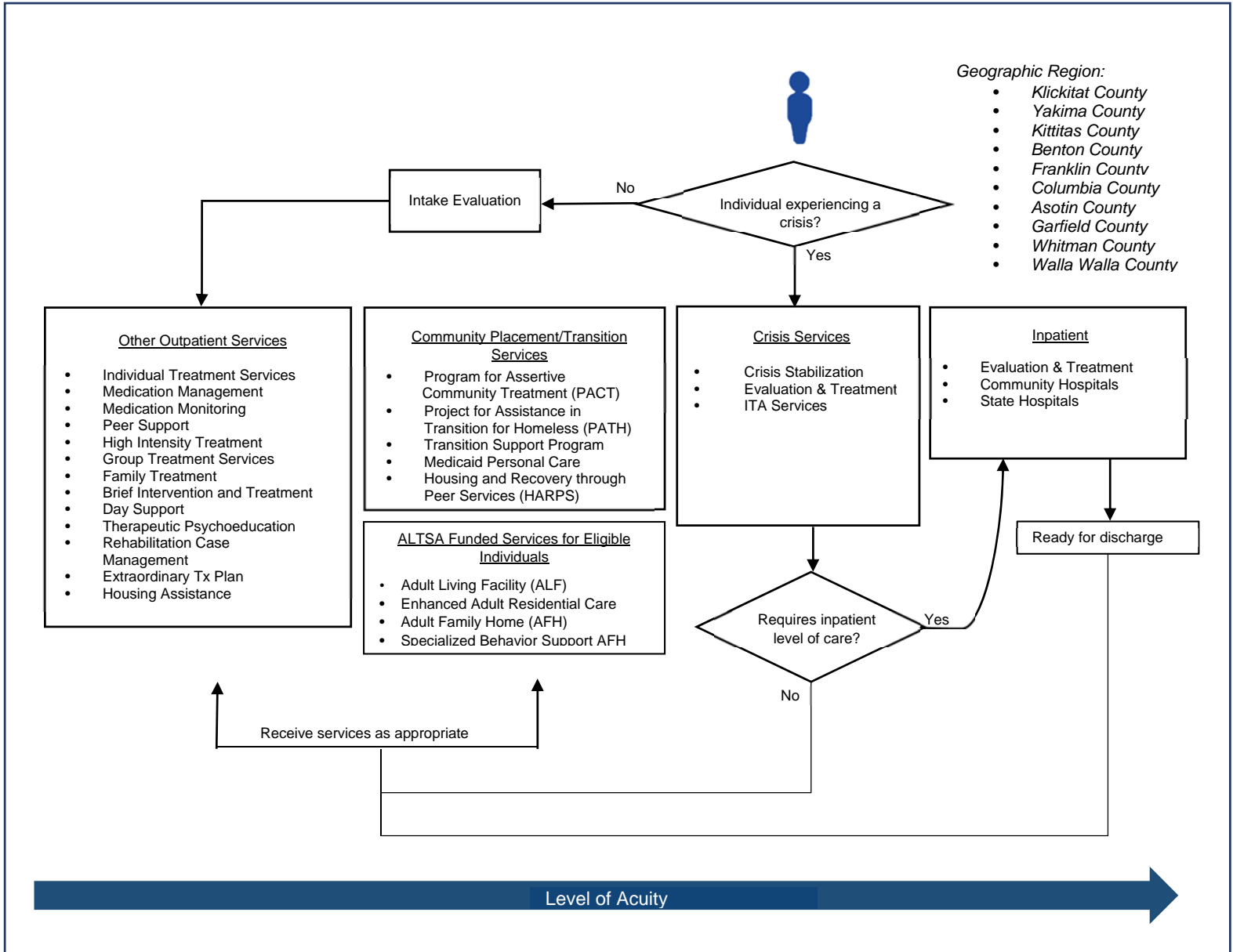
Service information was extracted from fiscal year 2015 Medicaid and non-Medicaid revenue and expenditure reports from RSNs, as BHOs were not established at that time. Due to the realignment of counties when BHOs were implemented, the county categories below do not completely align with the current BHO county organization. Further services were identified by reviewing BHO contract requirements, the member benefits handbook and data on Adult Family Living (AFL) and Adult Family Home (AFH) locations. Residential Support Services listed in each region are primarily funded through the AL TSA delivery system and are not typically funded by BHOs. BHOs can provide funding for personal care services which may be delivered in these settings. As BHOs are not required to report services and programs that are not funded by state and federal sources, the flow charts should not be read as a comprehensive offering of services available to individuals with behavioral health needs. For example, in King County, there are several other programs and services listed in the “Community Alternatives to Boarding Task Force Final Report” but these services are not included in the flow charts as this level of detail for services was not available for all BHOs, therefore their inclusion would result in a skewed comparison of services across geographic regions.

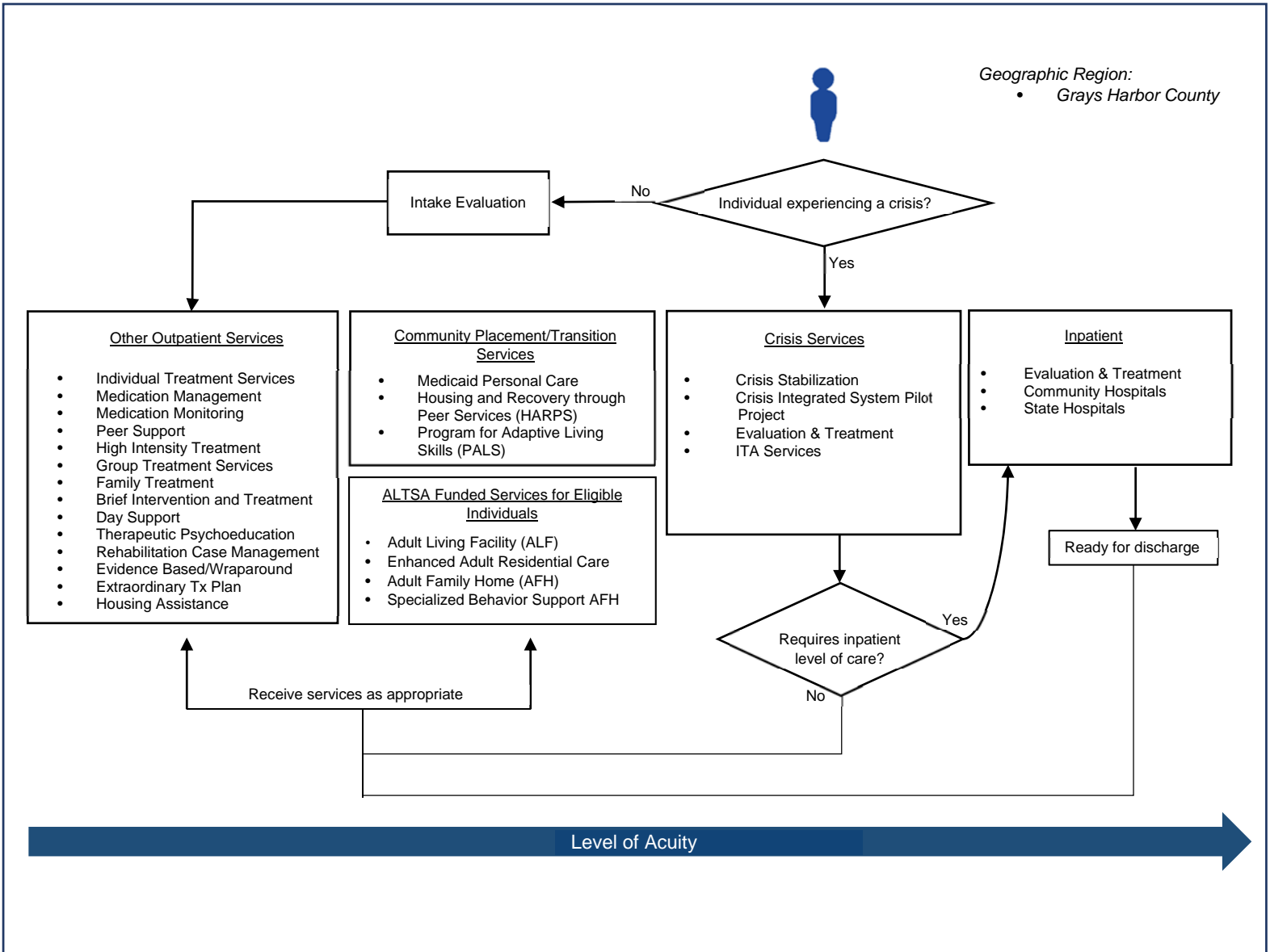
The flow charts illustrated in Figure 6 are meant to provide a high level overview of services individuals can access. For a detailed decision tree on Crisis and ITA processes, please refer to Appendix H.

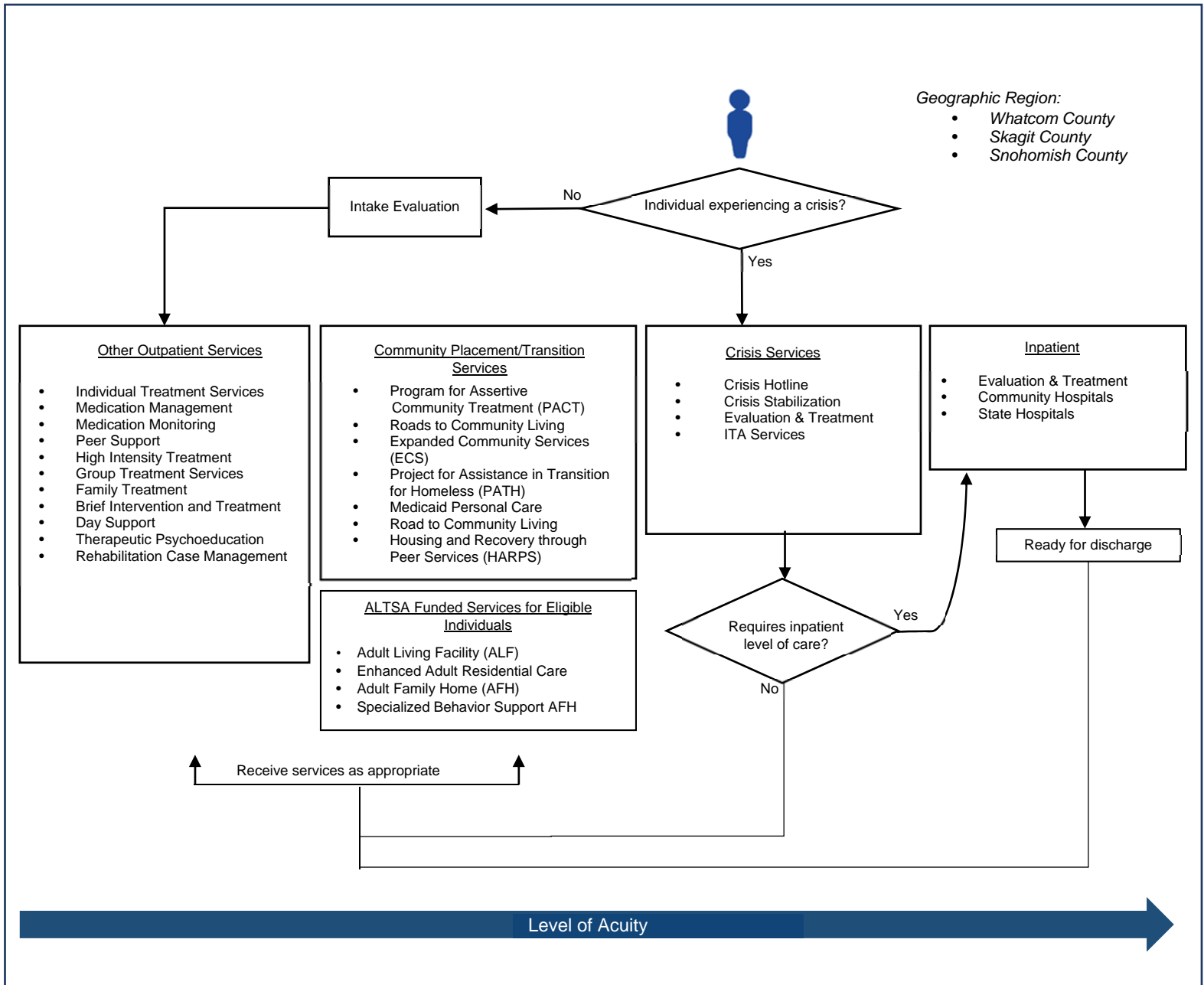
Figure 6. Behavioral Health Services Flow Charts by Geographic Region

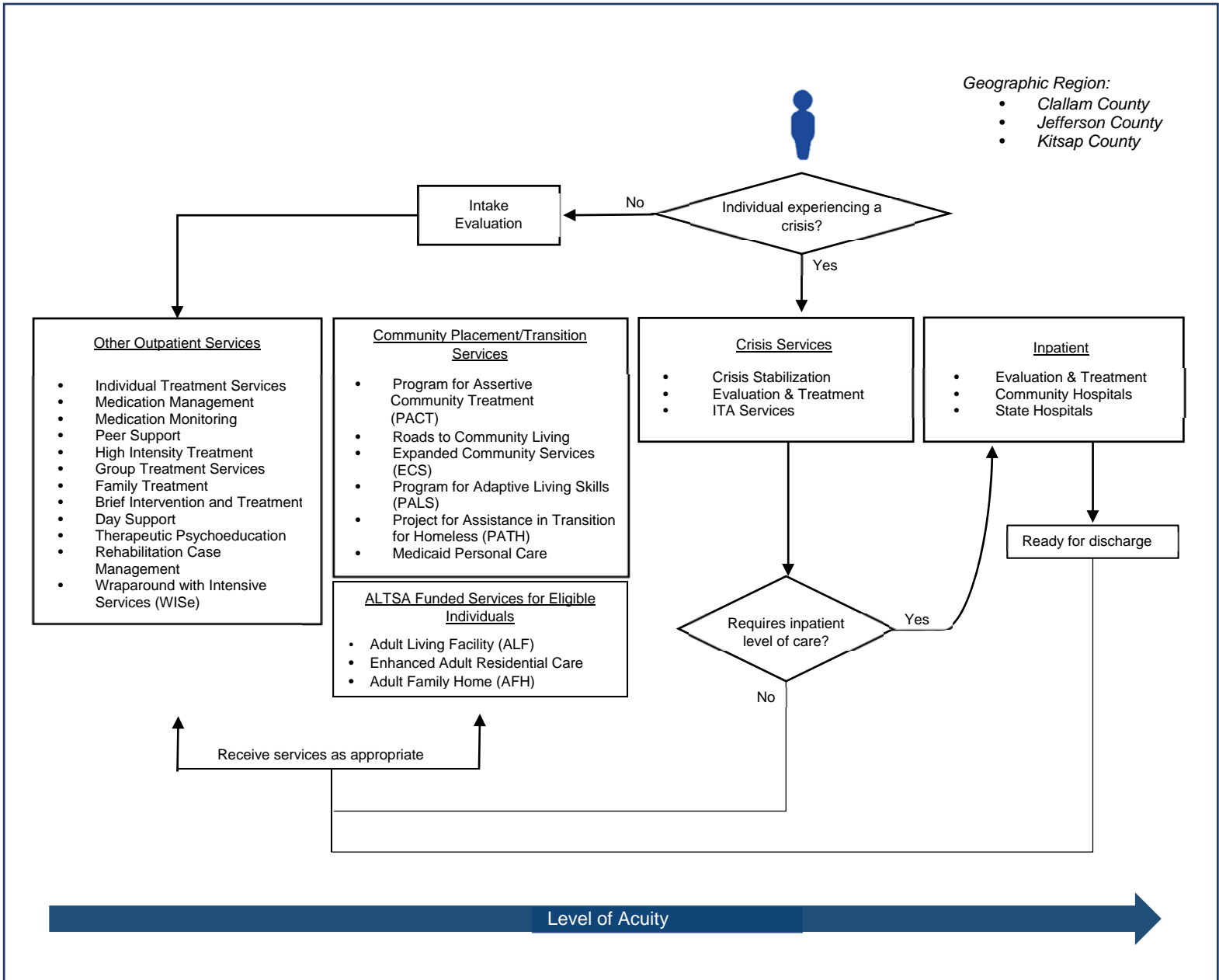


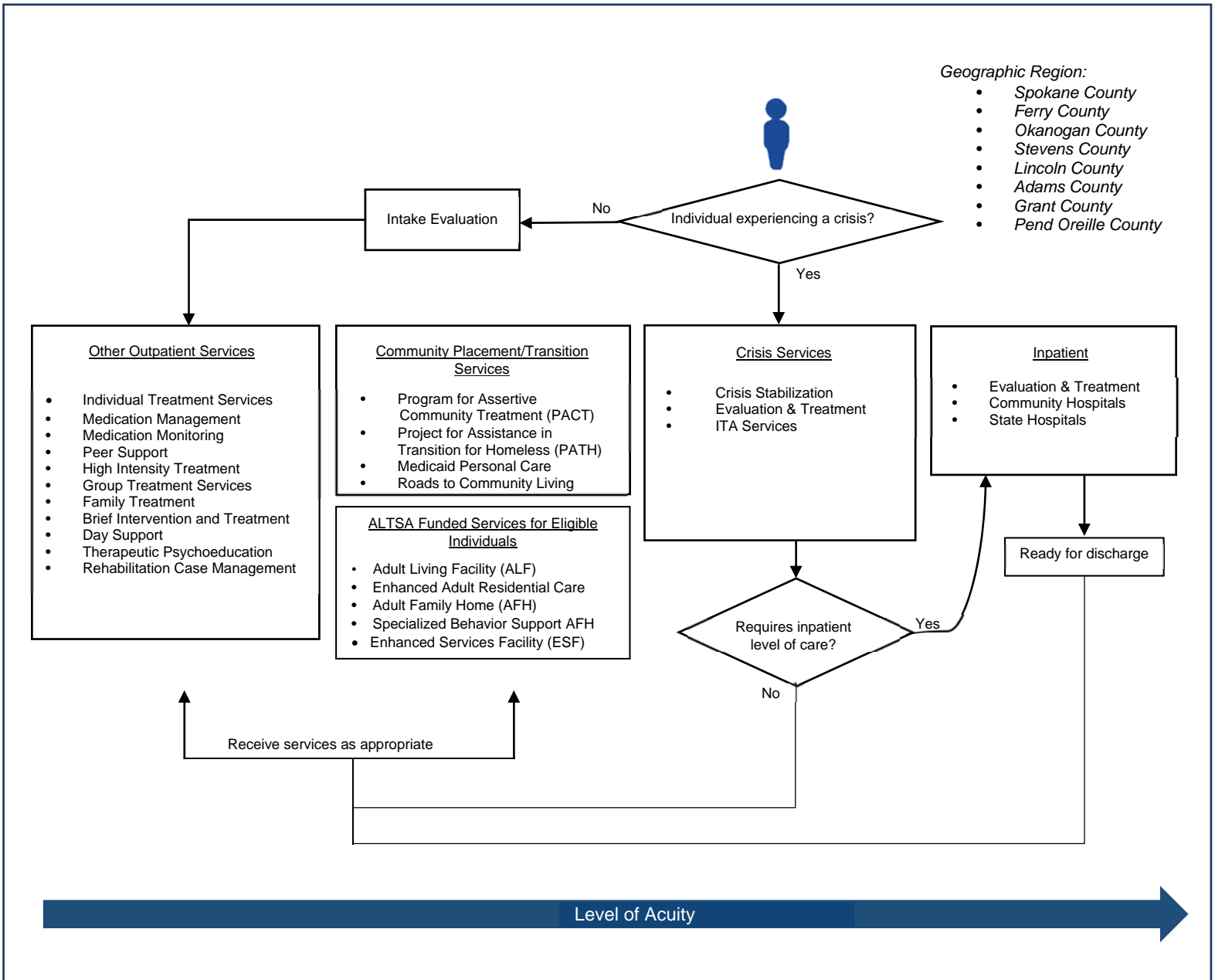


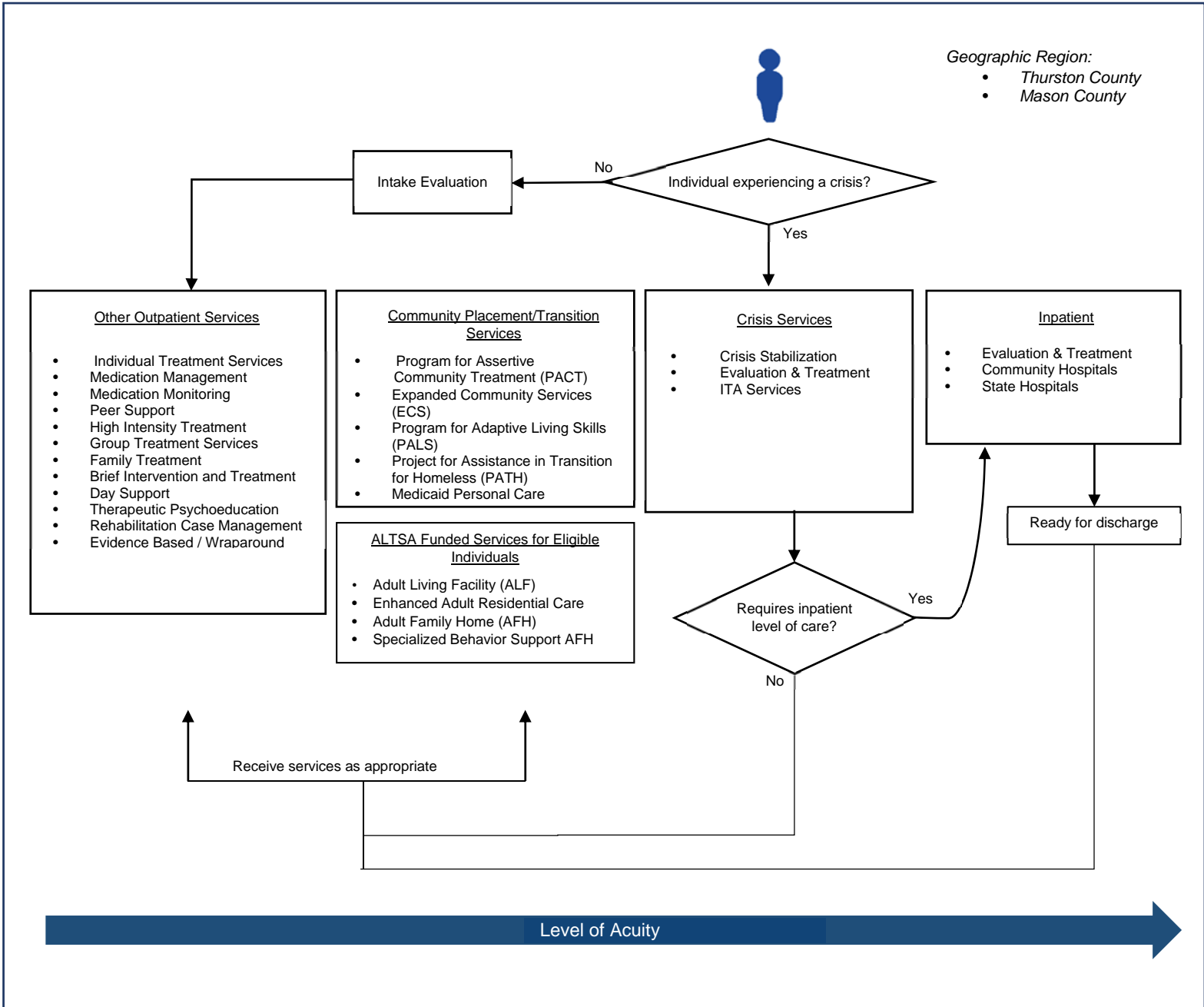


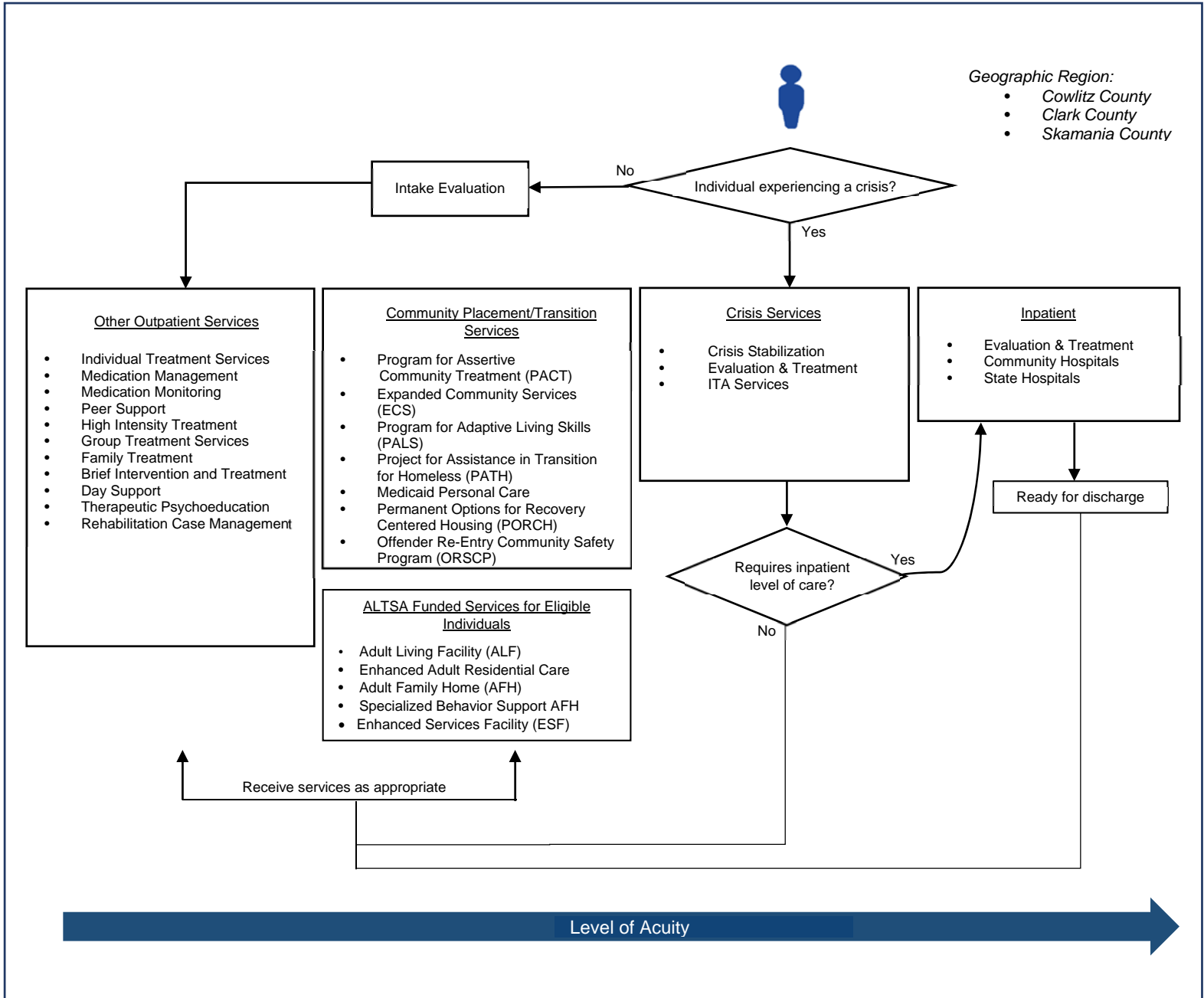


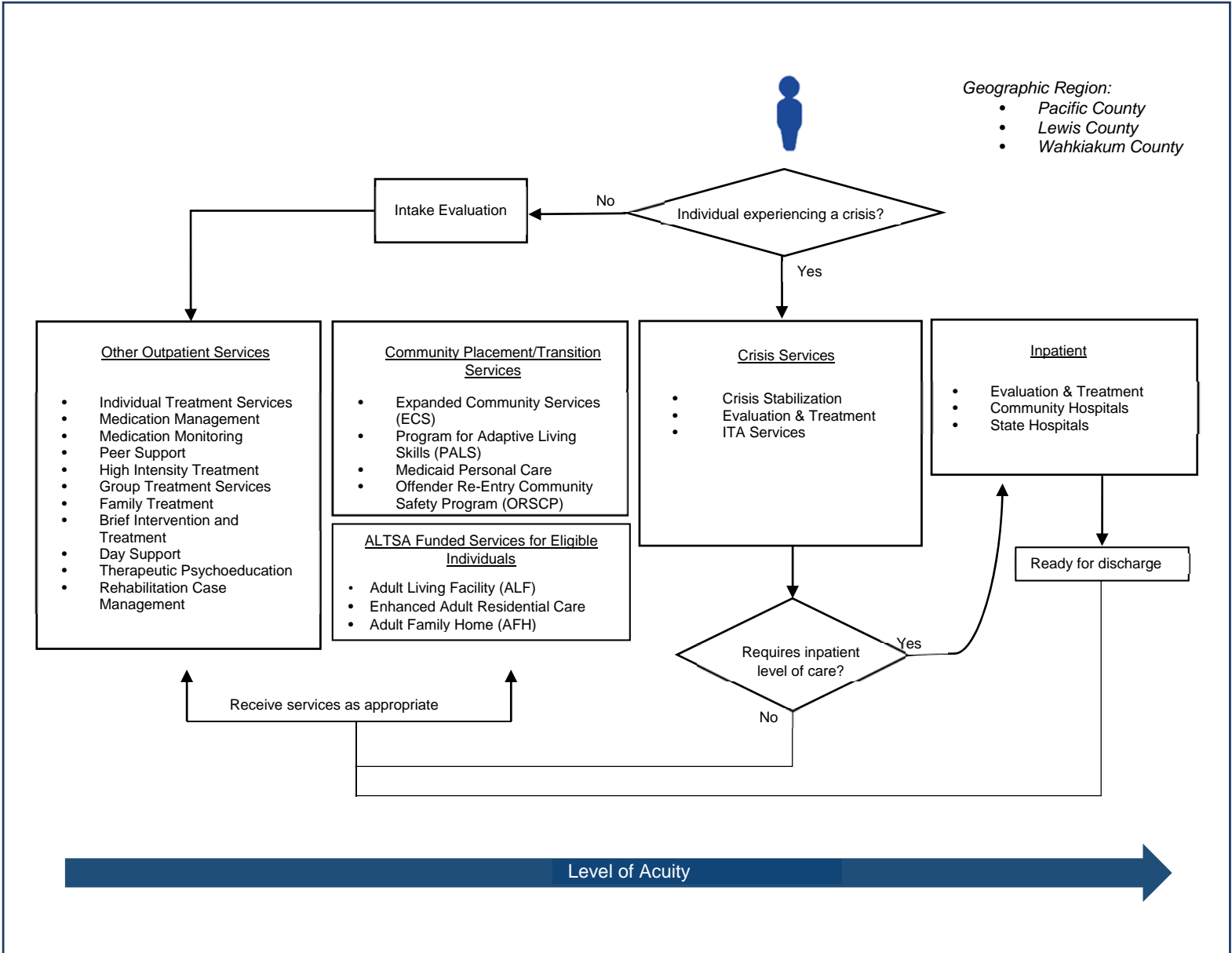


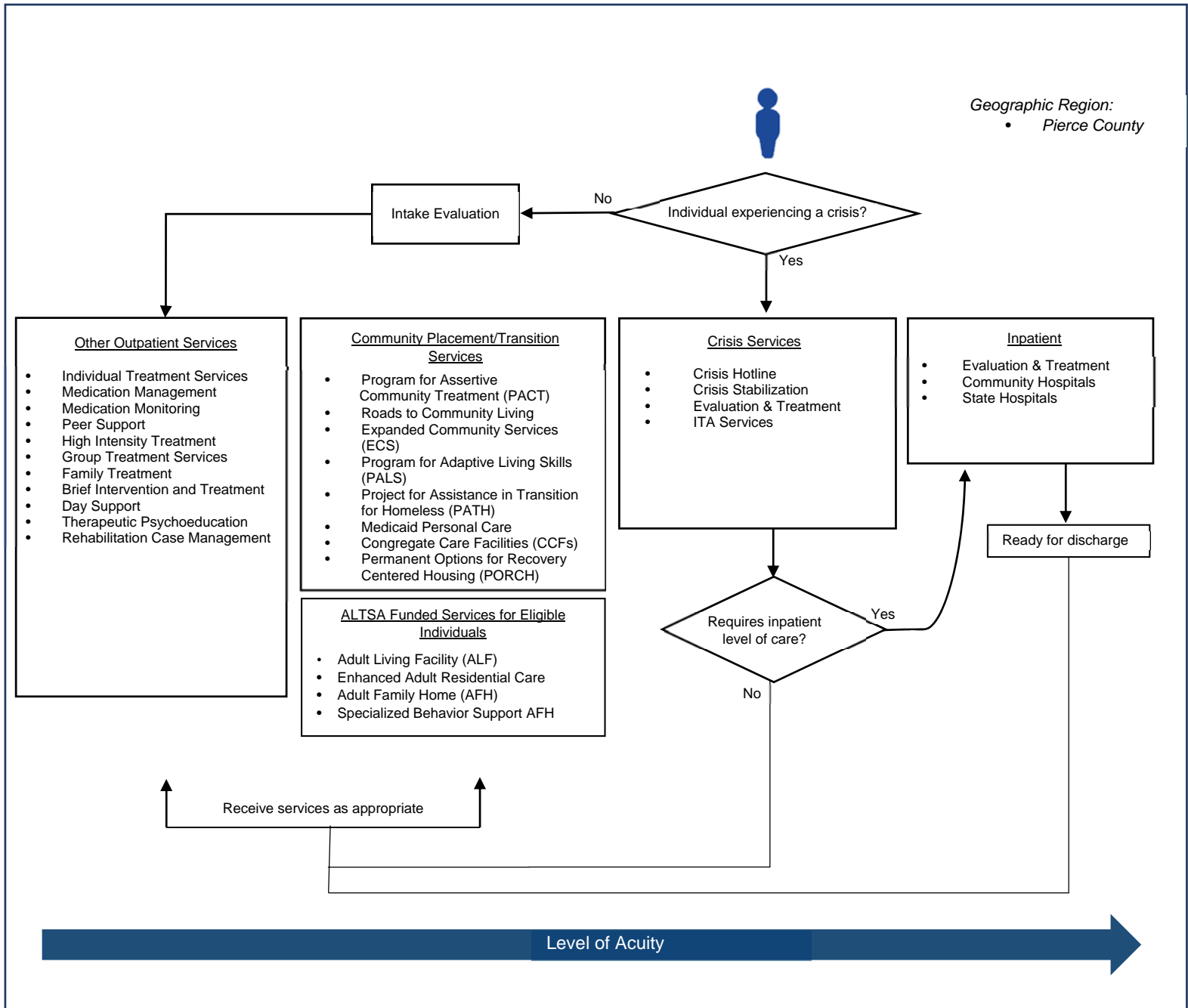












The behavioral health services funding table contains data from fiscal year 2015 Medicaid and non-Medicaid revenue and expenditures and is a compilation of reported services and funding from all RSNs. For funding sources for state hospitals, please refer to Section 4.5.

Table 35. Behavioral Health Services Funding Chart

Service Category	Service/Program	Funding Source(s)
Outpatient	Crisis Services	Medicaid, Non-Medicaid State Mental Health Contract (SMHC), Local Funds
	Freestanding Evaluation and Treatment	Medicaid, Non-Medicaid SMHC, Local Funds
	Mental Health Residential Treatment	Non-Medicaid SMHC
	Other State Plan Outpatient Treatment	Medicaid, Non-Medicaid SMHC, Local Funds
	Roads to Community Living	Non-Medicaid SMHC, Other Federal Funds
	Transition Support Program	Other State Funds (ESSB 5480)
	Direct Services	Residential
Evaluation and Treatment		Non-Medicaid SMHC, Other State Funds (ESSB 5480)
Inpatient Treatment		Medicaid, Non-Medicaid SMHC
ITA Commitment Services		Non-Medicaid SMHC, Local Funds
ITA Judicial/ITA Administrative		Non-Medicaid SMHC, Other State, Local Funds
ITA 180-day Commitment Hearings		Other State Funds
Medicaid Personal Care		Non-Medicaid SMHC
Housing Authority Program		Non-Medicaid SMHC, Local Funds
Next Day Appointment Program		Other State Funds (ESSB 5480)
Mobile Crisis Team		Other State Funds (ESSB 5480)
Jail Services		Non-Medicaid SMHC, Other State, Local Funds
Jail Services- Intensive Case Management		Medicaid
State Psychiatric Services		Non-Medicaid SMHC
Expanded Community Services (ECS)		Medicaid, Other State Funds
Program for Assertive Community Treatment (PACT)		Medicaid, Non-Medicaid SMHC, Other State Funds, Local Funds
Program for Adaptive Living Skill (PALS) Alternatives		Non-Medicaid SMHC, Other State Funds
Crisis Integrated System Pilot Project		Other State Funds
Offender Re-Entry Community Safety Program (ORCSP)		Other State Funds
Project for Assistance in Transition for Homeless (PATH)		Non-Medicaid SMHC, PATH Funds, Local Funds
Evidence Based/Wraparound (EBP)		Medicaid, Non-Medicaid SMHC, Local Funds
Wraparound with Intensive Services (WISe)		Medicaid
Permanent Options for Recovery Centered Housing (PORCH) (State pass-through)		Medicaid, Federal Funds
Geriatric Transition Team		Other State Funds
Congregate Care Facilities (CCFs)		Non-Medicaid SMHC
Triage		Non-Medicaid SMHC
HIV Program		Local Funds
Direct Service Support		Utilization Management and Quality Assurance
	Information Services	Medicaid, Non-Medicaid SMHC

Service Category	Service/Program	Funding Source(s)
	Public Education	Medicaid, Non-Medicaid SMHC, Other State Funds
	Crisis Telephone	Medicaid, Non-Medicaid SMHC
	Transportation	Medicaid, Non-Medicaid SMHC
	Interpreter Services	Medicaid, Non-Medicaid SMHC
	Ombudsman	Medicaid, Non-Medicaid SMHC
	Housing and Recovery through Peer Services (HARPS)	Other State Funds

4.9. Context from Other States

To provide context relative to Washington’s mental health system, PCG was asked to examine information from five other states on selected data points. The five peer states – Colorado, Illinois, Massachusetts, Minnesota and Oregon - were chosen by Washington based on a number of factors including demographics, geography, structure of the delivery system and features that Washington may want to consider for implementation.

State and Private Beds by Type

Table 36 compares psychiatric beds across Washington against the selected states, beginning with state-operated civil and forensic beds. Across all six states the average number of state-operated beds per 100,000 residents was 13.3. Washington ranked first in the number of beds per 100,000 people, with 16.9, followed closely by Oregon’s 16.2. At 9.7 beds per 100,000, Colorado had the lowest ratio but was only slightly higher than Illinois (10.1) on this metric.

Washington has a significantly higher ratio of civil beds to forensic compared to most of the selected states at 61.7 percent civil. The sole exception is Massachusetts, which has 65.8 percent civil beds. Among the other states, the majority of beds are forensic, led by Colorado with 67.2 percent forensic and Oregon with 63.7 percent forensic. Note that forensic patients requiring strict security in Massachusetts are treated in a separate facility run by the Department of Correction (DOC) rather than a health or human service agency.

It is important to note that the forensic bed figures represent *designated* forensic beds when in fact civil beds can be and often are used to treat forensic clients when demand for these beds exceeds capacity. Because commitment laws in many states prioritize beds for forensic admissions over civil, a significant number of beds designated as civil may be occupied by forensic patients at any point in time.

As an example, the Colorado Mental Health Institute at Pueblo (CMHIP) was primarily civil, but currently 95 percent of all of patients are forensic. Based on a 2010 consultant report recommendation, CMHIP restructured the delivery of treatment services to serve patients on units based on clinical need and level of risk rather than commitment status.⁴² Because of this change, every adult bed at CMHIP has the potential to be filled by a client meeting the criteria for admission regardless of legal standing.

⁴² Interview with Dr. Patrick Fox, Chief Medical Officer for the Colorado Department of Human Services. August 22, 2016.

Table 36. State and Private Beds by Type

Data Point	Source	WA	CO	IL	MA	MN	OR
Total State Population	U.S. Census 2015	7,170,351	5,456,574	12,859,995	6,794,422	5,489,594	4,028,977
Total State Medicaid Population	CMS Report June, 2016	1,776,851	1,356,251	3,088,448	1,650,379	1,027,909	1,035,319
Total State Beds 2016	State data	1,213	531	1,299	1,022	659	653
Total number of state beds per 100k population	PCG calculation	16.9	9.7	10.1	15.0	12.0	16.2
State Civil Beds 2016	State data	749	174	578	672	278	237
State Forensic Beds 2016	State data	464	357	721	350	381	416
Total number of civil beds per 100k population	PCG calculation	10.4	3.2	4.5	9.9	5.1	5.9
Total number of forensic beds per 100k population	PCG calculation	6.5	6.5	5.6	5.1	6.9	10.3
Total number of private psychiatric beds	*	792	830	4,031	2,399	1,082	n/a
FY2014 Per Capita Community Mental Health Expenditures	NOMS 2015	\$91.72	\$98.15	\$47.15	\$95.30	\$169.78	\$181.68
State Ranking for Per Capita Spending on Community Based Services	NRI SMHA Expenditures 2013	21	27	38	23	13	11
Ave LOS Civil (State hospitals, months)	NOMS 2015	2.2	1.6	0.4	1.7	1.2	4.1
Ave LOS NGRI (months)	TAC Report 2016; WA Data	ESH: 78 WSH: 39	106	67	6	85	32
State hospital readmission 30 days	NOMS 2015	2.6%	6.7%	12.4%	8.7%	14.4%	0.4%
State hospital readmission 180 days	NOMS 2015	10.4%	14.7%	19.3%	11.1%	26.6%	9.0%

*Private psychiatric bed data was culled from multiple sources including state hospital associations and other state sources. Data does not include evaluation and treatment beds, as such beds were not uniformly reported. Washington has 218 evaluation and treatment beds.

Summary of Facilities by State

Below is a brief summary by peer state of the state-operated psychiatric facilities, capacity, populations served and available programmatic information.

Colorado

Colorado has two state-operated psychiatric treatment centers. The Colorado Mental Health Institute at Pueblo serves primarily forensic patients and the Colorado Mental Health Institute at Fort Logan Denver serves civil patients.

Colorado Mental Health Institutes at Pueblo (CMHIP) has a total of 437 beds and is the only state facility in Colorado to have designated forensic services. As noted above, CMHIP no longer separates the two populations and is comprised of four treatment centers, which CMHIP describes as follows:

- The Admission Program provides psychiatric evaluation, treatment and recovery-oriented care, while addressing that patient's behavior and employing motivational interview strategies and techniques.
- The Restoration Program works with patients to develop healthy, professional relationships that deliver the right service, at the right time, to the right patients. The Program develops treatment alliances that foster hope and self-determination and creates opportunities for psychosocial treatments that address burdensomeness and lonesomeness.”⁴³
- The Cognitive Behavioral Program provides dialectic behavioral treatment (DBT) in a therapeutic environment to assist individuals diagnosed with co-morbid mental disorders. A subset of this program is the Circle Program, a dual-diagnosis 20-bed inpatient center for patients ages 18-65. The program lasts for 90 days and integrates a wide variety of services including 40 hours of group work per week, written “homework”, stress management technique classes, cognitive behavioral therapy (CBT), restorative yoga, acupuncture and much more. Patients are referred to the program via mental health centers, Department of Social Services, probation and parole officers, public defenders and judges.
- The Psychosocial Program provides mental health services to those with chronic mental illness with the goal of discharge to the least-restrictive community setting. The Psychosocial Program includes CMHIP's two geriatric units.

Colorado Mental Health Institute at Fort Logan Denver (CMHIFL) has a total of 94 adult beds broken into four units of 25, 24, 25 and 20 beds. All units serve clients who require acute psychiatric stabilization prior to community placement, as well as clients identified as difficult to place in the community. The fourth unit with 20 beds is designated specifically for male patients. Additionally, the statewide program for adult deaf/hearing impaired clients with mental illness is located at Fort Logan.⁴⁴ CMHIFL serves five community mental health centers in Colorado.

⁴³ Mental Health Institute at Pueblo: Services <https://sites.google.com/a/state.co.us/cdhs-behavioral-health/home/mental-health-institutes/mental-health-institutes-at-pueblo/services> accessed 8/18/2016

⁴⁴ Mental Health Institute at Fort Logan: <https://sites.google.com/a/state.co.us/cdhs-behavioral-health/home/mental-health-institutes/mental-health-institute-at-fort-logan> accessed 8/18/2016

Illinois

The Illinois Department of Human Services' Division of Mental Health (DMH) has oversight of the state's seven inpatient psychiatric facilities:

- Alton Mental Health Center: 125 beds (15 civil and 110 forensic)
- Elgin Mental Health Center: 419 beds (75 civil and 344 forensic)
- Chester Mental Health Center: this is the state's maximum security facility and has 284 beds (67 civil and 217 forensic)
- Chicago Read: 110 civil beds
- Choate Mental Health and Developmental Center: 79 civil beds
- Madden Mental Health Center: 150 civil beds
- McFarland Mental Health: 132 beds (82 civil and 50 forensic)

The DMH also manages 27 community hospitals with mental health units.

Massachusetts

Massachusetts has two Department of Mental Health (DMH)-run hospitals, one Department of Correction (DOC)-run hospital, two DMH-run units in Department of Public Health (DPH) hospitals and six DMH-run psychiatric units in community clinics, three of which have beds.

Between 1973 and 2010, DMH closed 10 of its public psychiatric hospitals, most of which were built in the mid 1800's and early 1900s. To replace these facilities, Massachusetts spent \$302 million to build the new Worcester Recovery Clinic and Hospital (WRCH). WRCH officially opened in 2012 as 320-bed recovery center with 260 adult beds and two adolescent units with 30 beds each. The facility is considered state-of-the-art and is designed to emulate familiar environments ranging from "house" to "neighborhood" to a "downtown" section, which surrounds a village green. It employs 1,200 staff members and has an estimated annual operating cost of \$60 million. Although more expensive than average, the state believes the investment will pay off in the long term in reduced re-hospitalizations.

Taunton State Hospital, with 45 beds, was nearly closed in 2012 but due to intensive involvement by local advocates and lawmakers was instead reduced to roughly a third of the hospital's original capacity. In 2016, Taunton became the state's treatment facility for civilly committed women with co-occurring mental health and substance use disorder issues. Prior to this move, these patients were treated at a correctional facility in Framingham.⁴⁵ Bridgewater State Hospital (BSH) is a psychiatric facility with 350 beds operated by the DOC and is the only strict-security forensic psychiatric facility in Massachusetts. BSH also serves men who have been civilly committed with co-occurring disorders and is set up to deliver specific psychiatric services to this population.

Table 37 presents an overview of the full array of state-operated inpatient psychiatric facilities in Massachusetts.

⁴⁵ Boston Globe Editorial Board. "Women Addicts Need Treatment Not Prison." Boston Globe, August 6, 2015. <https://www.bostonglobe.com/opinion/editorials/2015/08/06/women-addicts-need-treatment-not-prison/bAIF5Io2hDVIKz09RBKw5H/story.html>

Table 37. Massachusetts State-Operated Adult Inpatient Psychiatric Facilities

Facility	Type	Location	Services	Beds
Worcester Recovery Center and Hospital	DMH Operated State Hospital	Worcester, MA	Full range of inpatient psychiatric services including designated child and adolescent beds	260
Taunton State Hospital	DMH Operated State Hospital	Taunton, MA	Section 35 program on the grounds of Taunton State Hospital for women with SUD	45
The Hawthorne Mental Health Units at Tewksbury State Hospital	DMH Unit in Public Health Hospital	Tewksbury, MA	Inpatient unit at Department of Public Health facility	160
The Metro Boston Mental Health Units at Lemuel Shattuck Hospital	DMH Unit in Public Health Hospital	Jamaica Plain, MA	Inpatient unit at Department of Public Health facility	115
Solomon Carter Fuller Mental Health Center	Continuing Care Mental Health Center	Boston, MA	Continuing Care Inpatient beds	60
Pocasset Mental Health Center	Community Mental Health Center	Pocasset, MA	Acute Inpatient Beds	16
Corrigan Mental Health Center	Community Mental Health Center	Fall River, MA	Acute Inpatient Beds	16
Bridgewater State Hospital	DOC Operated State Hospital	Bridgewater, MA	DOC MH facility for forensic patients – only strict security forensic psychiatric facility in the state	350

Minnesota

Minnesota's state hospitals are operated by the Department of Human Services (DHS). In recent years, Minnesota placed significant emphasis on shifting from the delivery of inpatient psychiatric care in state-run hospitals to a recovery-oriented, community-based model. As part of this effort, Minnesota closed institutionally-based regional treatment centers in Brainerd and Fergus Falls, leaving only two institutional facilities, the Anoka-Metro Regional Treatment Center and the Minnesota Security Hospital. The state has simultaneously devoted resources to the creation of several smaller, community-based treatment facilities, of which there are now seven.

Anoka-Metro Regional Treatment Center is designed for patients with “multiple and complex conditions,” or “serious behavioral issues,” or are mentally ill and facing trial but not classified as mentally ill and dangerous.

Minnesota Security Hospital (MSH), located in St. Peter, is a secure treatment facility serving individuals who have been committed by the court as mentally ill and dangerous. MSH is operated by the Forensic Treatment Services subdivision within DHS.

Minnesota DHS is also responsible for 112 beds located within community hospitals, each with 16 beds, serving seven municipalities: Annandale, Baxter, Bemidji, Rochester, Fergus Falls, St. Peter and Alexandria.

DHS also operates a 16-bed Child and Adolescent Behavioral Health Center in Willmar.

Oregon

Oregon's Addictions and Mental Health Services Division (AMH) of the Oregon Health Authority runs Oregon State Hospital. The hospital is comprised of two campuses, both built recently to replace older facilities. When at capacity, the Salem campus may serve up to 620 patients and the Junction Campus (JC) may serve up to 175 starting in 2016. Between Fiscal Year 2015-2017 the Salem campus will operate 23 units and four cottages to serve 594 people. Many of the staff and patients now in the Salem campus were transplanted from the recently closed Portland campus.

The two campuses run several programs, such as a civil commitment program, a neuropsychiatric program, a guilty except for insanity program and aid and assist services. Additionally, OSH runs "Treatment Malls" which centralize active treatment by locating many treatment and educational opportunities in one place. It operates for 20 hours during weekdays to mimic work or school-day routines. By focusing on preparation for community reintegration, the "malls" help patients learn to manage illness and build skills in groups selected to meet patients' needs and interests.

Along with these two major hospitals, AMH makes services and beds available through contracts with community providers and state-operated facilities, including 36 community mental health programs and 16 coordinated care organizations.⁴⁶

Other Bed Types

Outside of state-operated psychiatric beds, PCG was asked to gather comparison information on two other classifications, community-based evaluation and treatment beds and private, non-profit psychiatric beds. To information on bed counts and classifications, PCG reached out to licensing departments and hospital associations in each state as well as contacts within the state agency responsible for oversight of the hospital system. The selected states vary considerably in how they capture and make available information about licensed beds. Consequently, varying levels of information were collected for each state.

Regarding the total number of community-based evaluation and treatment (E&T) beds for each state, PCG requested but did not receive this breakout for any of the selected states and thus was unable to compare Washington's E&T beds against other states. The selected states also could not clearly delineate between for-profit and non-profit beds in the private sector. The information summarized below consists of verified data regarding private psychiatric facilities (non-profit or for-profit) in the selected states.

⁴⁶<http://www.oregon.gov/oha/bhp/amhpac/PACDocs/OHA%208068%20Behavioral%20Health%20Strategic%20Plan-Final.pdf>

In 2015, Washington's community hospitals operated approximately 453 private involuntary beds in 13 hospitals and 151 private voluntary beds in eight hospitals. In 13 standalone evaluation and treatment centers, Washington had 218 private beds, for a total of 892 additional beds.

Based on 2016 information from the Colorado Department of Public Health and Environment, 18 facilities operated 830 private beds. Of those, 569 beds were located in psychiatric hospitals and 261 beds were located in psychiatric units in other hospitals.

Based on 2016 information from the Illinois Hospital Association, 86 hospitals operated 4,031 private psychiatric beds.

Based on 2014 information for the Massachusetts Department of Health and Human Services, 65 private psychiatric units operate 2,399 private psychiatric beds across 65 private psychiatric units. Of these beds, 1,039 were located in free standing hospitals or clinics and the other 1,360 beds were located in general hospitals. Two hundred and fifty beds were reserved specifically for children and adolescents and 406 beds were reserved specifically for geriatric patients. These beds were spread throughout three dedicated children and adolescent facilities and nine dedicated geriatric units.

In Fiscal Year 2014, Minnesota providers operated 1,082 private mental health beds across 35 facilities. This total includes 785 adult mental health beds across 28 facilities and 137 child and adolescent mental health beds in six different facilities.

Staffing for Forensic and Civil Beds

The selected states that provided information relative to staffing indicated that staffing levels generally vary not only by bed type (civil versus forensic) but also by unit, shift and acuity of the current patient population. Information provided is summarized below.

Colorado

At Colorado's Ft. Logan facility, which is limited to civil beds, the core ratios of direct nursing staff to patients for the co-ed units are 0.2 for day and evening shifts and 0.13 at night, while for the all-male unit the ratios are 0.24 and 0.14, respectively. Staffing levels are then adjusted based on acuity. Acuity data is collected daily and reviewed regularly and staff increases or decreases are determined based on the acuity assessment from the Charge Nurse or Nurse Manager.

The Pueblo facility has more variation in staffing patterns due to a larger mix of bed and unit types. Because any bed may be used for a forensic patient as needed, the number of forensic patients fluctuates and staffing must be adjusted accordingly. Unit staff to bed ratios per shift therefore range from 0.43 to 0.08 for high functioning patients.

Illinois

Illinois provided high level information on staffing ratios at each of the seven state-operated facilities based on calculations contained in a 2015 report by the interim Assistant Central Hospital Administrator. The report is responsive to a DMH performance measure that established a standard of a 2.0 to 1 staff-to-patient ratio. Below is a table showing the ratios calculated at the time for each facility.

Table 38. Staffing Ratios by Facility

Facility	Staff to Patient Ratio	Facility Bed Type
Alton	2.07	Mostly forensic
Chester	1.84	Mostly forensic
Chicago-Read	2.04	Mostly civil
Choate	1.70	Mostly civil
Elgin	1.80	Mostly forensic
McFarland	1.72	Civil/Forensic
Madden	2.05	Civil

DMH noted that specially trained Security Therapy Aide staff are assigned to forensic units along with the usual multi-disciplinary clinical staff representing psychiatry, nursing, social work, activity therapy, psychology, recovery specialist and occupational therapy.

DMH further commented that the DMH hospital designated as maximum security has a low staff to patient ratio in comparison to other DMH hospitals; however, more structured programming, more supervised and restricted in-hospital movement, individual sleeping rooms and specially trained staff help to manage and meet the clinical needs of the patient population without increased staffing.

For context relative to staffing costs at the DMH facilities, PCG reviewed fiscal year 2016 operating budget information that included the following staffing figures and costs relative to the state-run psychiatric facilities:

- Alton: additional \$482,700 in funding to support the addition of 8 FTE direct care staff for total cost of \$21.2 in Personal Services costs for 266.8 FTE (\$79,406 per FTE)
- Chicago-Read: maintain 302.3 FTE staff at \$24.5 million in Personal Services costs (\$81,123 per FTE)
- Choate MH and Developmental Center: Reduction of 65.2 FTEs for investment in community funding (\$62,667 per FTE – does not distinguish between MH and DC staff)
- Elgin: maintain 751.1 FTE staff at \$57.9 million in Personal Services costs (\$77,134 per FTE)
- Madden: maintain 318.3 FTE staff at \$27.9 million in Personal Services costs (\$87,706 per FTE)
- McFarland: additional \$211,600 to support the addition of 3 FTE staff for total cost of \$19.2 million in Personal Services costs for 247.4 FTE (\$77,639 per FTE)⁴⁷

Massachusetts

Although information about staffing levels within civil and forensic facilities was not readily available for all Massachusetts facilities, PCG was able to obtain high level staffing information for the two DMH operated state psychiatric hospitals, as outlined in Tables 39 below. The categories shown do not represent clinical leadership, but rather focus on those providing direct patient care. Note that Bridgewater State Hospital is typically an outlier in comparison to the other state-operated facilities. Efforts to reform Bridgewater State Hospital continue in Massachusetts.

⁴⁷ Illinois DHS fiscal year 2016 Budget Briefing. <http://www.dhs.state.il.us/page.aspx?item=75158>

Table 39. Direct Care Staff to Patient Ratios for State Psychiatric Hospitals

FTE per patient	Worcester Recovery Center and Hospital	Taunton State Hospital
Mental Health Services	2.32	1.77
Other Direct Medical	0.28	0.25
Total Direct	2.60	2.02

Although staffing ratios in Massachusetts state hospitals are higher than in several other states, staffing concerns still exist. Recent stories from the Worcester facility have reported unusually high incidents of staff injury. Those filing the reports state that an inadequate number of nurses and other staff members is a leading cause of the spike. Bridgewater State Hospital, as noted above, continues to be a subject of public scrutiny resulting from decades of legal action against the facility.⁴⁸

Minnesota

Minnesota also indicated that staffing determinations are made by the Charge Registered Nurse (RN) or RN Supervisor and noted the following as common reasons for adjusting staffing ratios/mix: one or more patients on 1:1 or frequent observation, case mix of patient population, scheduled training for staff, increase/decrease in admissions or census, emergency staffing issues and use of seclusion or restraint. The Nursing Supervisor is responsible for reviewing acuity patterns for trends monthly and reports to Nursing Leadership and Local Authority. For forensic beds, the current staffing compliment is 2.00 per patient.

Minnesota has placed a significant focus on mental health workforce issues in recent years, including state hospitals. Nurse staffing ratios represent a major focal point. In 2013, the MN Legislature considered a bill that would have enabled outside professional organizations to mandate nurse staffing levels at hospitals. The final bill, HF588/SF471 was a compromise that required hospitals to develop a core staffing plan for each patient care unit in consultation with appropriate medical staff and submit the plan to the Minnesota Hospital Association (MHA) for posting on the Minnesota Hospital Quality Report Website. Hospitals were also required to report to MHA the actual direct care hours per patient and per unit on a quarterly basis. Finally, the Department of Health was tasked with convening a workgroup to study the correlation between nurse staffing levels and patient outcomes and to present it to the Legislature by January 2015.

Oregon

In line with the recommendation set out in a Department of Justice (DOJ) report, Oregon has increased staffing at state hospitals in the near term while planning for strategic decreases over time. According to the most recent information readily available, the Salem Campus has 1,802 positions per 1,801.82 FTE and the Junction City campus has 428 positions per 428.00 FTE. Overtime per patient has decreased from over 45 hours per patient in July of 2013 to approximately 32 hours per patient in January 2015.

⁴⁸ Rezendes, Michael and Ransom, Jan. "Group blasts Bridgewater State after patient suicide." *The Boston Globe*. June 27, 2016. <https://www.bostonglobe.com/metro/2016/06/27/watchdog-group-makes-recommendations-bridgewater-state-hospital-report-suicide/zRgZ8ZvAek8queofp6CHhK/story.html>

Workers compensation claims from patient assault/control have also decreased between 2012 and 2014 and lost days of work dropped from 1,857 in 2012 to 1,023 in 2014. Additionally, the total costs incurred from said claims decreased from \$182,204.61 in 2012 to \$127,376.71 in 2014.

Along with these changes, Oregon has placed a particular emphasis on continuing staff training. Areas of focus include: Trauma informed care, Collaborative problem solving, Short term assessment of risk treatability (START), Case formulation, Treatment care planning, Safe communication, Psychiatric emergency response teams (PERT) and Safe containment.⁴⁹

Utilization

Peer state comparisons are also useful in understanding how the state uses its institutional and community resources. The penetration rate per 1,000 population measures the utilization of all state mental health services. Washington ranks in the middle, close to the national average and the median of the selected state percentages. Community utilization per 1000 measures the relative use of community mental health resources and again, Washington appears to be in the middle of the peer states and close to the national average.

In terms of utilization of state hospitals, Washington is somewhat higher than most of the peer states but still below the national average (0.44.) Washington serves a higher proportion of individuals in state hospitals than three of its peer states: Colorado, Minnesota and Oregon.

Washington has the lowest 30-day readmission rate and the second lowest 180-day readmission rate. This statistic posed positive and negative implications. Low readmissions may indicate that once individuals are discharged to the community, they tend to access stable community services. However, a recent DSHS report found that patients who received timely outpatient care had higher readmission rates but significantly lower mortality rates, suggesting that readmission was preventing larger health issues from occurring.⁵⁰

⁴⁹ <https://www.oregon.gov/oha/Budget2015/OHA%20Oregon%20State%20Hospital%20Presentation.pdf>

⁵⁰ Mancuso, D. 2015. Quality Indicators and Outcomes for Persons Discharged from State Psychiatric Hospitals. DSHS Research and Data Analysis Division.

Table 40. Type and Duration of Mental Health Services

Data Point	Source	WA	CO	IL	MA	MN	OR
Penetration Rate per 100k	NOMS 2015	24.21	23.70	9.78	4.97	39.04	33.14
State hospital utilization per 100k	NOMS 2015	0.40	0.29	0.56	0.44	0.34	0.36
Community Utilization per 100k	NOMS 2015	23.97	23.17	9.78	4.87	38.81	32.62
Wait list for forensic beds	TAC Report 2016	176	100	62	0	0	0
Average wait time for forensic beds (days)	TAC Report 2016	43	n/a	38	0	0	0
Average Length of Stay for Discharged State Hospital Patients (days)	NOMS 2015	67	48	11	52	36	122
Average Length of Stay for Not Guilty by Reason of Insanity (days)	TAC Report 2016	n/a	3,176	2,001	180*	2,555	945
State Hospital Readmissions: 30 days	NOMS 2015	2.6%	6.7%	12.4%	8.7%	14.4%	0.4%
State Hospital Readmissions: 180 days	NOMS 2015	10.4%	14.7%	19.3%	11.1%	26.6%	9.0%

*Turns into a civil commitment after 180 days

As shown in Table 40, among the selected states, WA ranks second to last in terms of fiscal year 2014 State Mental Health Authority (SMHA) per capita spending on community mental health expenditures although is somewhat comparable to the average per capita spend of \$113.96 across the six states. Washington's rate of \$91.72 in per capita spending is nearly half of the \$181.68 spent by Oregon but nearly double the \$47.15 spent by Illinois, the state with the lowest level of per capita spending among the peers.

Table 41. Expenditure Data for State-Operated Mental Health Programs

Data Point	Source	WA	CO	IL	MA	MN	OR
FY2014 Per Capita Community Mental Health Expenditures	NOMS 2015	\$91.72	\$98.15	\$47.15	\$95.30	\$169.78	\$181.68
FY2014 Community Percent of Total State Mental Health Authority (SMHA) Spending	NOMS 2015	71.40	80.52	70.72	84.14	87.03	77.36
SMHA Expenditures Per Inpatient Day, Civil (and rank among the states)	NRI FY13	\$589.70 (33)	\$665.30 (27)	\$496.20 (42)	\$770.10 (18) ^a	\$1,060.5 0 (8)	\$946.80 (12)
SMHA Expenditures Per Inpatient Day, Forensic (and rank among the states)	NRI FY13	\$356.40 (36)	\$627.90 (18)	\$327.90 (39)	\$769.00 (11) ^a	\$552.60 (24)	\$1,052.9 0 (5)
State Medicaid Enrollment	CMS Monthly Medicaid Report	1,776,851	1,356,251	3,088,448	1,650,379	1,027,909	1,035,319
Percent of Total State Population Enrolled in Medicaid	PCG calculation	24.78	24.86	24.02	24.29	18.72	25.70

^a MA Medicaid revenues for community programs are not included

^b MA expenditures include funds for mental health services in jails or prisons

Relative to the percent of total SMHA spending on community programs, Washington is again second to lowest among the peer states at 71 percent. In light of its targeted push toward community-based programs, Minnesota has the highest percentage of spending on community programs among the peer states, at 87 percent.

Payment Models

In an effort to contain costs and use funding more efficiently, the selected states have all initiated or implemented redesign of traditional fee-for-service payment models for at least some Medicaid beneficiaries

and have sought to integrate the provision of behavioral health services into restructured payment systems. Below are examples from each peer state of such initiatives.

Colorado

On July 1, 2017, Colorado plans to integrate behavioral health and physical health services for Medicaid Accountable Care Collaborative beneficiaries under one administrative entity in each region of the state. Currently, behavioral health services are the responsibility of the capitated BHOs and physical health services are the responsibility of the managed FFS Regional Care Coordination Organizations (RCCOs). The new model will continue to reimburse behavioral health services at a capitated rate, while physical health services will be reimbursed using a managed FFS model. Over the five-year contract, the physical health service payment structure will be changed to better align with behavioral health payments. Colorado plans to release an RFP for the new administrative entities in the fall of 2016.⁵¹

Illinois

Illinois began formal integration of physical and behavioral health care for Medicaid beneficiaries in 2012 through its Care Coordination Innovations Project, which facilitated partnerships among primary care physicians, hospitals and mental health and addiction treatment provider organizations. Under that structure, Care Coordination Entities (CCEs) and Accountable Care Entities (ACEs) received fee-for-service payments plus a per member per month payment for care coordination. In 2016, all CCEs and ACEs will be transitioned to full-risk managed care plans. These initiatives were prompted by an Illinois law requiring that no less than half of the state's Medicaid beneficiaries be enrolled in a managed care entity providing care coordination.

Massachusetts

In recent years, Massachusetts has been aggressively overhauling finance of the health system, including behavioral health, in an effort to contain costs and focus on alternative payment models in lieu of traditional fee-for-service. Overall health care costs have risen steadily in Massachusetts and as of January 2016, MassHealth (Medicaid and the Children's Health Insurance Program) alone accounted for nearly 40 percent of the state's \$39.6b budget.⁵² To manage this cost, Massachusetts is planning to move the state to an integrated accountable care model. Like Colorado, by the end of December 2016, MassHealth plans to launch a pilot accountable care organization (ACO) program with the intent of full rollout by October 2017. A major focus of the new structure is on better integrating members' physical, behavioral health (BH) and long term services and support (LTSS) needs, as well as strengthening linkages to social services. A range of ACO options would accommodate varying degrees of provider readiness to assume risk and provide an ongoing role for Medicaid MCOs:

- Model A: "Integrated ACO/MCO" approach, in which an ACO integrates with a single MCO, assuming full, two-sided insurance risk on prospective capitation.
- Model B: "Direct to ACO" approach, in which the state provides insurer functions (building on the current State-run Primary Care Clinician (PCC) plan) for an ACO assuming two-sided retrospectively adjudicated performance risk, with the option to advance to prospective capitation in later years.

⁵¹ Mandros, Athena. "The Landscape of Behavioral Health Carve-Ins." *Open Minds*. September 2, 2015.

⁵² Dayal McLuskey, Priyanka. "Governor Would Hold MassHealth Spending Increase to 5." *The Boston Globe*. January 28, 2016.

- Model C: "MCO-supported ACO" approach, in which an ACO enters into one of three tracks for two-sided retrospective performance risk-sharing contracts with multiple MCOs, with MCOs providing insurance functions as they do today.⁵³

Minnesota

The vast majority of Minnesota's Medicaid recipients are enrolled in managed care organizations. According to the 2014 Medicaid Managed Care Enrollment report, of Minnesota's 1,112,174 Medicaid enrollees, an estimated 791,004 (71 percent) are enrolled in Comprehensive Managed Care with fully integrated behavioral health services. Since 2011, Minnesota has relied on competitive bidding in its selection of Medicaid MCOs. Combined with other reforms, this change has resulted in an estimated \$1.65 billion in savings as of 2015.⁵⁴ A 2013 analysis of Minnesota's Managed Care programs indicated very high ranking in access to care and patient satisfaction relative to Consumer Assessment of Healthcare Providers (CAHPS) key satisfaction indicators. The study also found that both managed care and fee-for-service delivery systems in Minnesota show higher costs for seniors and people with disabilities than other Medicaid programs nationwide, but noted that the higher costs are associated with more expansive health plan benefits and strong quality indicators. Minnesota ranks in the 97th percentile nationwide for preventive care for seniors.

Oregon

Oregon has fully integrated behavioral health services into all of its managed care plans. As of 2012, Oregon is using regional Coordinated Care Organizations to manage both physical and behavioral health benefits for Medicaid beneficiaries under a global budget. Within a global budget framework, CCOs are required to track screening and follow-up for members diagnosed with clinical depression. This CCO model replaced the older Oregon Health Plan that included behavioral health, dental and transportation in a separate carve out. The CCOs will be held accountable for performance based metrics and quality standards that align with industry standards, new systems of governance and payment incentives that reward improved health outcomes. CCOs that do not meet quality standards may be required to pursue specified improvement efforts. In 2013, the state planned to withhold 1 percent of CCO payments, contingent on submitting timely and accurate encounter data and to develop quality and access metrics that in the future will be eligible for payments from a quality incentive pool.⁵⁵

Services to Individuals with Both Behavioral Health (BH) and Long Term Support and Service (LTSS) Needs

One of the most complicated populations to serve are individuals with both behavioral health and long term service and support (LTSS) needs. Patients often require more time, support and resources than populations who fall into either discrete BH or LTSS categories. This level of care causes strain on community health care systems as more states move away from institutional care for these individuals. Since 1980 Medicaid expenditures on nursing homes have fallen from 67 percent of all LTSS expenditures to roughly 35 percent in 2014. In that same time period, section 1916 waivers for community-based care have risen to almost 30 percent of Medicaid LTSS spending. Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IDD) spending also decreased drastically in a push to move away from institutionalizing people with

⁵³ Boozang, Patricia et al. "Massachusetts Releases Details on Forthcoming DSRIP Waiver Proposal." *Manatt on Medicaid*. May 9, 2016.

⁵⁴ "Medicaid Payment and Delivery System Innovation: Minnesota's Experience." Presentation by Marie Zimmerman, Medicaid Director. 2015.

⁵⁵ Deborah Brown and Tricia McGinnis, "Considerations for Integrating Behavioral Health Services within Medicaid Accountable Care Organizations" Center for Health Care Strategies, Inc. July 2014. <http://www.chcs.org/media/ACO-LC-BH-Integration-Paper-0709141.pdf>
Managed Care in Oregon 2014 <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/downloads/oregon-mcp.pdf>

LTSS needs. From almost 25 percent of all spending in 1980, ICF/IDD spending has fallen to just 7 percent of the total in 2014. Personal care services have also seen an increase along with all other home and community based services. Together these community services now make up the majority of LTSS expenditures⁵⁶. Continuing this trend, states are creating community based programs that support both BH and LTSS. The following outlines some of these initiatives in the five selected states.

Colorado:

Colorado has received a Community Mental Health Supports (CMHS) Waiver for its Medicaid program. This waiver specifically provides assistance to people with a mental illness that require long-term supports and services to remain in a community setting. To qualify for the program, individuals must require long-term support services at a level comparable to services typically provided in a nursing facility. The eligibility group is defined as a person experiencing a severe and persistent mental health need that requires assistance with one or more Activities of Daily Living (ADL) who:

- Is 18 years of age or older with a severe and persistent mental health need.
- Currently has or at any time during the past year leading up to assessment has a diagnosable mental, behavioral or emotional disorder of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual of Mental Disorders (DSM-5).
- Has a disorder that is episodic, recurrent or has persistent features, but may vary in terms of severity and disabling effects.
- Has resulted in functional impairment which substantially interferes with or limits one or more major activities.

As of February 2016, 236 unique providers were participating in the Community Mental Health Supports Waiver. Although outcome data related to client measures was not readily available, a scorecard related to provider performance showed a significant amount of variation in provider compliance related to specific “indicators of isolation” used to gauge client integration.

The Colorado Choice Transitions (CCT) program is designed to help transition Medicaid clients out of nursing homes and long-term care facilities and into home and community-based settings supported by enhanced services to promote independence. Transitional behavioral health services are provided by a qualified paraprofessional to support a member during the transition period to mitigate issues, symptoms and/or behaviors that may negatively affect the member’s stability in the community.

Eligibility Requirements for CCT are as follows:

- Meet Long-Term care Medicaid eligibility requirements (determined by an assigned case manager).
- Currently reside in a nursing facility and have been there for at least 90 consecutive days.
- Be willing to move into qualified housing.

In July of 2012, Colorado Governor Hickenlooper signed an executive order creating the Office of Community Living and the Community Living Advisory Groups⁵⁷. The goal of this order is to “redesign all

⁵⁶ Audra Wenslow, Steve Eiken, and Kate Sredl, “Improving the Balance: The Evolution of Medicaid Expenditures for Long-Term Services and Supports (LTSS), fiscal years 1981-2014” June 3, 2016. (Pp 7-9) <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/downloads/evolution-ltss-expenditures.pdf>

⁵⁷ <https://www.colorado.gov/pacific/hcpf/office-community-living>

aspects of the long-term services and supports delivery system, including services models, payment structures and data systems to create efficient and person-centered care.”⁵⁸

Illinois:

The state of Illinois contracted with two Managed Care Organizations (Aetna and Centene-IlliniCare) to establish an Integrated Care Program (ICP) for Medicaid clients. The initial phase will serve nearly 40,000 seniors and individuals with disabilities (SPD) covered by Medicaid. The ICP model creates an integrated delivery system, bringing together primary care physicians, specialists, hospitals and a wide variety of other providers who will focus on the health, behavioral health and social needs of Medicaid clients to achieve improvements in health. Each client is assigned a care manager to coordinate his or her care and ensure that needed services and supports are provided while avoiding unnecessary healthcare procedures. The Integrated Care Program is a collaboration among the Departments of Healthcare and Family Services, Human Services and Aging. ICP is being implemented in different phases; Phase II adds long-term services and supports to the service package for the 40,000 individuals currently eligible for the ICP program. This includes nursing facility and home- and community-based services (“waivers”) for those who need them.⁵⁹

Illinois has also submitted a waiver request to CMS to implement a Health Homes initiative for Medicaid clients with chronic conditions. Although not exclusive to behavioral health, the proposed approach includes mental health and substance abuse as qualifying chronic conditions. Health homes will be managed by existing MCOs and proposed funding structure includes the following:

- MCOs/MCCNs: Reallocate care coordination dollars included in the MCO’s capitation rate and provide additional monies for high-risk enrollees.
- ACEs/CCEs: Reallocate care coordination fee to health home population and additional monies for high risk enrollees.
- All organizations will be subject to a quality withhold.

Massachusetts:

As noted above, MassHealth recently announced plans to introduce Accountable Care Organizations in lieu of traditional fee-for-service for Medicaid recipients. ACOs will be incented to partner with community-based expertise for behavioral health, LTSS and build linkages to social services and will have access to Delivery System Reform Incentive Payment (DSRIP) funding designated explicitly for addressing social determinants and offering “flexible services” not traditionally reimbursed but likely to improve health outcomes (e.g., air conditioner for children with asthma, housing supports, etc.)

Minnesota:

Behavioral Health Homes began operating as a Medical Assistance (MA) covered service in Minnesota in July 2016 and is designed to address the needs of individuals across the primary care, mental health, substance use disorder treatment, long-term services and supports and social service components of the health care delivery system.

Through the delivery of behavioral health home services, individuals will have their comprehensive physical, behavioral health and social service needs addressed in a coordinated manner. The program consists of a

⁵⁸ Executive Order Establishing The Office of Community Living, Office of the Governor, July 5, 2012.

https://www.colorado.gov/pacific/sites/default/files/Executive%20Order%20Office%20of%20Community%20Living_0.pdf

⁵⁹ Illinois Department of Healthcare and Family Services. <https://www.illinois.gov/hfs/medicalproviders/cc/icp/Pages/default.aspx>

health wellness assessment and subsequent development of a health action plan to address chronic conditions, ongoing coordination of care between behavioral and physical health and coordination with non-clinical services so that people will have their health care coordinated with social and community supports. Behavioral health home services will also support individuals and families in developing skills to improve health literacy, wellness and self-management.

Special Needs BasicCare (SNBC) SNBC is a voluntary managed care program for people with disabilities ages 18 through 64 who have Medical Assistance. Enrollees may have a care coordinator or navigator to help them get health care and support services. Some SNBC health plans coordinate with other payers, including Medicare Parts A, B and D for enrollees who have that coverage and some plans are contracted with CMS to integrate Medicare and Medicaid benefit sets.

Oregon:

Long term services and supports are provided in a DHS Aging and People with Disabilities licensed care setting in conjunction with AMH contractors to provide outside intensive mental health supports. With increased funding from the state legislature, APD and AMH were able to expand services to an additional 10 individuals. In 2015, APD partnered with local community based long term care providers to offer community based services to a total of more than 110 individuals; these services include programs for people with TBI, advanced dementia and co-occurring mental health issues and extreme behaviors.

The HUB project is based in Multnomah County and is funded through an APD Innovations Fund Grant for Services to Seniors and People with Disabilities. The program provides intensive, ongoing case management, peer-based mental health and substance abuse outreach and support and personal care services to Medicaid eligible individuals. To be eligible for these services, the individual must be at risk due to medical needs, a SUD and/or mental illness and unstable housing. The project is in its pilot phase and expects to serve between 30 and 45 individuals to start. Due to its pilot nature, outcome data is not yet available.

4.10.Key Findings

State hospitals face significant utilization issues. For most civil bed types, both state hospitals are experiencing occupancy rates above 85 percent. These issues are exacerbated in the urban areas of the western region of the state, where both the state hospital and the surrounding community hospitals and evaluation and treatment centers all face capacity strain. Western State Hospital is further impacted by a high number of forensic “flips” to civil status without effective placement strategies. Importantly, although formal wait list data for Eastern State Hospital indicates relatively low numbers, this data does not represent individuals who cannot access the system at all and may misrepresent actual need. Primary diagnoses of dementia and developmental disabilities at admission to the state hospitals, although relatively small, may indicate a lack of specialized resources in other settings.

Community resources for adult residential facilities are available, but there are difficulties in placing certain types of patients. For example, patients in the state hospitals that are eligible for a Medicaid level of nursing care and have high ADL needs are easier to place since the CARE system assigns high payment rates for them. Patients that have specialized problems and do not have a high level of ADL needs may not even be eligible for Medicaid level of service and accessing any HCA home and community based waiver service is more difficult.

Community resources for individuals with complex needs who may pose health and safety risks to themselves or others are only available in some locations in the state, which poses challenges when attempting to place a patient in their home community.

Community resources across the continuum of care operate in disparate systems, which may complicate a patient or provider's ability to navigate the system and successfully place patients in the appropriate setting.

Quantifying unmet need and availability of services by geographic area requires further study. Lack of a uniform and comprehensive assessment across all provider types by geographic location and their relative ability to accept new patients hinders the study of appropriate utilization.

Lack of electronic record keeping and modern data systems at the state hospitals may pose an additional barrier to discharge. In many instances, paper-based systems currently support care transitions. Record transfer in a paper-based system requires additional administrative time and lack of standardization leads to inconsistent reporting of patient information. Planning to move toward behavioral and physical health integration will be complicated by a lack of continuity across these systems as many physical health providers have adopted electronic systems.

Other states face similar challenges in placing patients in the appropriate treatment setting. While many states have made progress on deinstitutionalization, similar challenges in appropriately funding community resources have been experienced. Minnesota represents a best practice example of efficient, system-wide focus on community-based care.

Unit staffing at the state hospitals appears lean in comparison to the states selected for this review. Although reporting differences confound a more detailed comparison, total direct care staff to patient ratios in many of the states reviewed were 10 to 50 percent higher than Washington, meaning more staff members are available per patient in other states.

5. National Best Practices

5.1. Role of State Hospitals

The role of the state hospital for individuals with acute behavioral health needs has shifted considerably since the advent of such facilities in the eighteenth century. These shifts are reflected in extreme fluctuations in the number of beds at state psychiatric facilities, from a peak of approximately 558,900 in 1955 to an estimated 37,679 in 2016⁶⁰. This scaling down of the state hospital system nationwide is a response to recognition that the behavioral health needs of an individual are best addressed in the least restrictive setting possible – ideally his or her home community - when appropriate and where the requisite services and supports are available. Nonetheless, there is broad recognition that not all patients may be treated in the community and that the state has an important role to play in providing inpatient psychiatric care for certain populations.

Appropriate Population to be Served

Research suggests that the appropriate population for treatment in a state-operated psychiatric facility generally includes individuals whose circumstances are not conducive to safe or effective treatment in a community setting. Among the considerations that may determine whether an individual meets this description are specific and/or co-occurring diagnoses, violent or inappropriate behaviors, criminal history or activity and indigent and/or uninsured status. For many states, an increased focus on building community-based capacity for inpatient psychiatric care has reduced civil population of state psychiatric hospitals to the most medically and behaviorally complex patients with significantly longer than average lengths of stay.

Commitment Status

Increasingly, state hospital beds are being occupied – and, in some cases, prioritized – for individuals at various stages of involvement with the criminal justice system. Across the nation, state-operated psychiatric facilities have seen a demographic shift toward a greater prevalence of forensic patients entering their doors, often resulting in significant strain on the capacity of these facilities to treat civil patients. This nationwide trend is not likely to abate in the near future.

According to a June 2016 report from the Treatment Advocacy Center (TAC), in 15 states more than 50 percent of remaining state hospital beds were occupied by forensic patients.⁶⁰ These estimates are likely low due to the fact that the study did not account for all forensic beds within a state. For example, Massachusetts is listed as having zero forensic beds but actually has 350 beds in its Department of Correction-operated Bridgewater State Hospital. The study further notes that in a sample of 25 states with an average of approximately six beds per 100,000 people, 50.5 percent of beds were occupied by patients found not guilty by reason of insanity (NGRI), many of whom spend decades or a lifetime confined to inpatient psychiatric care.⁶⁰ The emphasis on forensic care in state psychiatric hospitals is also evident in expenditure data. In fiscal year 2013, the percentage of state mental health authority-controlled expenditures for forensic patients topped

⁶⁰ *Going, Going, Gone: Trends and Consequences of Eliminating State Psychiatric Beds, 2016*. Treatment Advocacy Center. 2016.

50 percent in at least ten states, with California and Maryland devoting the most resources to this population at 73.7 percent and 73.3 percent, respectively.⁶¹

Despite the trends of increased demand for and expenditures related to forensic patients, the expected ongoing need for state hospital beds must be considered in the context of several considerations. First, justice-involved individuals requiring behavioral health services who likely pose a threat to themselves or others will require placement in a secure facility or unit, which typically means placement at a state hospital. Because they tend to maintain multiple units with varying levels of security, state hospitals are generally able to accept a broader range of patients than private hospitals.⁶⁴ However, the ability of state facilities to accommodate varying levels of security requirements is contingent on the availability of beds within these facilities which, as demonstrated by the many states currently dealing with long waitlists and backlogs for state beds, is not always assumed. The referral of a justice-involved individual for psychiatric services requires immediate attention and failure to promptly find a placement for that individual can and has had significant legal ramifications for states. Thus, projecting anticipated need for forensic beds and ensuring an adequate supply of beds are of the highest priority for many states.

Another important data point to consider is average length of stay (ALOS) for NGRI admitted patients. As noted above, NGRI patients often remain for years or decades in state-operated psychiatric facilities and as the primary placement option for these individuals, examining historical trend and current census data to determine ongoing need for beds to address the needs of this population is key. Of course, options such as conditional release programs may have an impact on mitigating the need for NGRI beds over the long term, although anticipating trends related to these programs is challenging since their use is at the discretion of the justice system.

While demand for forensic beds at state hospitals has been increasing, other established and emerging trends and practices have the potential to offset this rising demand. The increased reliance by states on utilizing community-based providers to conduct forensic evaluations has been successful in diverting individuals from entering state hospitals for this purpose. Thus, a determination of bed need must consider the availability of community-based providers to perform this function against anticipated need for forensic evaluations based on projections of need for these services. Additionally, many states have developed Competency to Stand Trial (CST) restoration services in jails and/or in the community; such programs are expected to proliferate in coming years and are described further in Section 5.2 of this report.

Other initiatives with longer-term impact on forensic admissions to state hospitals that may be harder to quantify include diversion services, such as mental health courts and crisis intervention teams (CIT), whose intent is to limit the involvement of individuals with the justice system and direct them toward treatment prior to being arrested (CIT) or incarcerated (mental health courts.) Although CIT has been in operation for decades, in recent years it has been increasingly recognized as a best practice that not only has the potential to divert individuals in crisis from arrest (and possible eventual commitment) but also improves the ability of law enforcement to understand and appropriately address the needs of these individuals.

Mental health courts, although still emerging as a common offering, have demonstrated results in reducing recidivism and re-arrest among participants, which over the long term may result in reductions in the number

⁶¹ Table 16: SMHA-Controlled Mental Health Expenditures for Forensic and Sex Offender Services in State Psychiatric Hospitals, fiscal year 2013. NRI. www.nri-inc.org

of individuals requiring adjudication and potential referral for evaluation and treatment as the availability of these courts becomes more widespread.

Treatment Needs and Diagnoses

Regarding diagnoses, the most frequently cited conditions that are likely to necessitate prolonged inpatient care are severe psychotic disorders such as schizophrenia and severe bipolar disorder. Part of the reason for this trend is the higher prevalence of concurrent medical conditions among this population including hypertension, obesity, diabetes and asthma, among others. A 2012 study notes that an estimated more than half of patients with schizophrenia also suffer from a chronic medical problem and suggests that co-occurrence of physical medical problems has been associated with poorer outcomes for psychiatric conditions, greater severity of psychiatric symptoms and increased incidence of non-compliance with treatment.⁶²

Based on data from 2011 (as published in 2012), mood disorders and schizophrenia are the two most frequent principal diagnoses among hospitalizations involving mental health or substance use disorder (MH/SUD) conditions nationwide. Mood disorders was the sixth most common diagnosis among all hospitalizations, accounting for nearly 900,000 hospital stays. Further, mood disorders and schizophrenia had the highest number of all-cause 30-day hospital readmissions among adult Medicaid patients and patients residing in the lowest income communities had a higher rate of readmission with schizophrenia than patients residing in higher income communities. Finally, hospital stays for both mood disorders and schizophrenia were significantly longer than stays for non-MH/SUD conditions, at 6.6. and 10.4 days, respectively, versus 4.8 days.⁶³

To effectively determine the population likely to be appropriate for prolonged care in state-operated psychiatric facilities, it is important to analyze diagnostic information to identify the most prevalent and frequently occurring conditions and correlate average length of stay and delivery of services to that population. Post-discharge analysis of this information can help to clarify which patients may have been appropriate for treatment in a setting other than a state-operated facility and may assist with diversion of such cases in the future. Information on those patients whose conditions appear most appropriately treated in a state-operated facility may be used to develop or refine sample profiles or guidance on which patients are most appropriately treated in a state-operated facility. This information must also be considered in the context of trends related to occurrence of specific psychiatric conditions within the population served by a facility, although admittedly the level of granularity required for meaningful projections may be difficult to obtain from either public or private sources.

Because they are often responsible for treating patients with particularly complex needs and/or those requiring extended stays in inpatient psychiatric care, state-operated psychiatric facilities are also regularly confronted with cases of difficult-to-discharge patients who present one or more barriers to discharge such as complex medical conditions, “inappropriate behaviors” and “potentially problematic sexual or other behaviors that would complicate their outplacement and could present risks to themselves or others.”⁶⁴

⁶² Douzenis, Athanassios, et al. “Factors Affecting Hospital Stay in Psychiatric Patients: The Role of Active Comorbidity.” *BMC Health Services Research*. 2012.

⁶³ Heslin KC (AHRQ), Weiss AJ (Truven Health Analytics). Hospital Readmissions Involving Psychiatric Disorders, 2012. HCUP Statistical Brief #189. May 2015. Agency for Healthcare Research and Quality, Rockville, MD.

⁶⁴ Fisher, William H. et al. “The Changing Role of the State Psychiatric Hospital.” *Health Affairs* 28, no.3 (2009): 676-684.

Many states maintain a listing of barriers to discharge as a means of identifying those circumstances prohibiting individuals clinically ready for discharge from leaving the facility. The list may indicate how many individuals in each category are awaiting discharge at a point in time; analysis of this list over time to identify trends allows for identification of persistent issues and presents an opportunity to address these, including with appropriate stakeholders.

Equally important to clearly defining the role of the state hospital in the continuum of care is ensuring that all relevant stakeholders understand this role including patients and consumers, community and hospital providers and in particular those responsible for decision making related to the evaluation and placement of consumers with acute behavioral health needs. Although Washington has a number of checks involved in the civil commitment process to ensure that individuals not appropriate for a state hospital setting are directed elsewhere for treatment, clearly identifying which individuals meet the criteria for placement at a state-run facility will help to alleviate inappropriate referrals.

Appropriate Size and Configuration of Facilities

Determining the appropriate size of state-operated psychiatric facilities is not an exact science and no established standard exists for making this determination. Ultimately, decisions are the result of careful analysis of a number of critical factors that seek to achieve balance within a state's overall continuum of care. This information must be regularly reviewed, analyzed and updated to reflect and anticipate trends and changes within the system of care that are likely to have a direct impact on state-operated psychiatric facility utilization and related needs.

An important starting point is assessing the need for total number of beds within the system of care. In this regard, examining published standards may be helpful to establishment of a baseline. For example, a June 2016 report by the Treatment Advocacy Center (TAC) acknowledges that relative to psychiatric bed need, "Health policy experts converge around a minimum requirement of 40 to 60 inpatient beds per 100,000 people to meet demand. However, empirical research related to any bed target to desired outcomes – much less to differentiate targets for the many categories of psychiatric need and facilities that meet them – has not been conducted."⁶⁰ The report goes on to suggest that data exists to develop these targets and that the federal government should use tested tools to assess bed need and develop realistic hospital bed targets by type, facility and setting.

Absent formal guidance from the federal level, meaningful state-level analysis of bed need is likely to take into account a number of factors including:

- total number of public and private beds in the state classified by type and population served
- total population demographics for the state and designated regions
- prevalence estimates for mental health and substance use disorder, including SMI, both in the general population and among justice-involved individuals
- estimates of unmet need for treatment
- data on average length of stay relative to specific conditions/diagnoses
- trends for forensic and civil admissions at state hospitals
- projections and trends related to individuals involved with the criminal justice system

Highlighting the challenges associated with accurately gauging the need for psychiatric beds, many states struggle to even capture accurate information about the total number of psychiatric beds operating within the state. Hospital licensing departments typically maintain information about the number of licensed facilities but may not capture detailed data about units or bed classifications and/or may struggle to keep this information current, including relative to budgeted versus licensed beds. Colorado, for example, recently convened a mental health task force to examine how Coloradans in crises will receive mental health services and a key component of the effort is gaining more accurate information about the number and type of psychiatric beds available throughout the state. Other states have found more success in this arena through the establishment of bed registries that capture detailed information about facilities statewide. For example, the Minnesota Mental Health Access website, set up as a joint venture between the Department of Human Services and the Minnesota Hospital Association (MHA), offers providers real-time access to information regarding facilities and available beds. Results can be sorted by type of facility, age of patient and geographic location. On recent review, most facilities had updated their information within 6 hours. Users are able to see how many beds are available at a particular facility and click the facility name to access additional detail regarding contact information, referral options, level of care offered, admission requirements and payment options. The website locates inpatient acute care mental health beds as well as community-based services within the state of Minnesota.

The state of Texas recently undertook an extensive 10-year report to examine the system for providing services to individuals served by the state psychiatric hospital system. The plan provides a very informative roadmap for how a state might go about assessing the current and future need for state hospital beds by examining several of the factors noted above and using established methodologies to gauge forensic and civil beds needs as well as unmet and latent need within the state's population. The study also examined design principles and facility costs related to the ten state hospitals, many of which were in need of significant improvements or replacement at the time of the study.

Below is an example of the methodology used to assess Unmet Need for Community Beds used in the Texas analysis. Projections related to prevalence and treatment need were adapted from SAMHSA data from the 2012 National Survey on Drug Use and Health:

Table 41. Texas Estimate of Unmet Need for Community Beds

Unmet Need	2014
Total State Population	26,623,655
Percent of State Population that is Incarcerated	6.0%
Non-Incarcerated State Population	25,026,236
Percent of Population with Serious Mental Illness (SMI)	4.1%
SMI Population	1,026,076
Percent of SMI Population w/ Perceived Unmet Need for Treatment	38.6%
SMI Population w/ Perceived Unmet Need for Treatment	396,065
Percent of Population with SMI that Felt the Need for Treatment	82.8%
SMI Population that Felt the Need for Treatment	327,942
Percent of SMI Cases Requiring Inpatient Services	6.0%
SMI Population that would Utilize Inpatient Services	19,677
Community Average Length of Stay (days)	6.7
Community Days	131,833
Planned Occupancy Rate	90%
Community Bed Need	401

The above methodology considers a broad array of factors likely to impact service utilization and bed need and, though not an exact science, suggests a possible formula that could be adapted to data specific to Washington to inform the development of facility design and bed projections for the future.

Align Evidence-Based Practices Across Hospitals and Community Providers

State agencies and mental health providers across the country continue to place emphasis on the importance of incorporating Evidence-Based Practice (EBP) into the provision of care for individuals with behavioral health needs. The American Psychological Association (APA) defines EBP as “the integration of the best available research with clinical expertise in the context of patient characteristics, culture and preferences” and further notes that the use of EBP in psychology “promotes effective psychological practice and enhances public health by applying empirically supported principles of psychological assessment, case formulation, therapeutic relationship and intervention.”⁶⁵ SAMHSA maintains a registry of National Evidence-Based Programs and Practices with a wealth of information and resources related to EBP.

New Jersey has convened a State Hospital Evidence-Based Practice Consultation Initiative, a collaborative effort between the Department of Psychiatric Rehabilitation and the Counseling Professions at Rutgers’ School of Health Professions. Funded by the New Jersey Department of Mental Health Services, the mission of the program is to improve consumer outcomes in New Jersey’s five state hospitals by enhancing staff workforce competencies and implementing EBP such as Illness Management and Recovery into the hospital delivery system. Professionals from Rutgers provide training and mentoring to hospital staff and assist the hospitals in adopting policies and procedures that reflect psychiatric rehabilitation principles and consumer choice and increase opportunities for patients to gain the skills necessary for a successful return to the community.

Focus on Recovery

Psychiatric care delivered in a state-operated hospital setting is often considered to be of a different nature than that which is provided in community-based or other hospital settings. State-run facilities are frequently thought of as offering ‘custodial care’ that addresses the basic needs and security of patients, either those whose conditions make them physically or socially vulnerable or those who may pose a danger to others. The provision of this type of care has often lent itself to a singular focus by state hospital administration and staff, leaving little room for addressing patient needs, goals and preferences beyond medical treatment and basic care and security.

Increasingly, state hospitals are reconsidering this approach to patient care and seeking ways to introduce or expand recovery-oriented principles and practices into the care regimen, recognizing that failure to believe in and promote the idea that patients can and will recover from their conditions means that they almost certainly will not. The recovery model is focused on the concept of providing treatment that will allow patients to recover from acute episodes and eventually return to the community. Introduction and adoption of a recovery-oriented model may be met with resistance by hospital personnel accustomed to operating in an entirely

⁶⁵ “Evidence-Based Practice in Psychology.” *American Psychologist*. Volume 61. May-June 2006.

different manner so strong leadership and dedication to improved performance over a long period of time are essential to effective implementation.

Oregon State Hospital (OSH) is an example of an institution that has undergone significant transformation in recent years to move toward a recovery-oriented model of care. In 2004, the Governor's Mental Health Task Force made the decision to add the recovery perspective into hospital standards and in 2011 the hospital adopted the phrase "Hope, Safety and Recovery" to reflect its new standards. A key component of the model was adding psychosocial rehabilitation services to the model of care, including through the introduction of "treatment malls" where patients are expected to interact with one another and have access to services such as a gym and hair salon that help them develop the skills and habits required for successful community living. Another important component is self-empowerment, including the use of advanced psychiatric directives that allow patients to describe and document preferences for how they should be treated in the event of a psychiatric crisis.⁶⁶

Based on 2015 Mental Health National Outcome Measures (NOMS) data, Oregon State Hospital's 30-day and 180-day readmission rates are significantly lower than national averages, suggesting that these recovery-oriented practices may be achieving the intended effect. The 30-day readmission rate was just 0.4 percent compared to 8.2 percent nationally while the 180-day rate was less than half of the national rate, at 9.0 percent versus 18.5 percent.⁶⁷

Provide Peer Support and Substance Use Services Within Hospitals

Building on the concept of a recovery-oriented model of care, state-operated psychiatric facilities are beginning to consider incorporation of services traditionally delivered in outpatient settings but with promise for improving outcomes, reducing length of stay and decreasing readmissions related to inpatient care; notable among these services are peer support and substance use treatment.

The availability of peer support programs has increased considerably in recent years as recognition of the positive impact of these programs on individual recovery and funding mechanisms to support them have emerged. However, the use of peer support programs has been primarily seen in community-based rather than inpatient settings, even though evidence suggests that the application of peer support may result in fewer and shorter hospital stays for individuals with serious mental illness. A study conducted by the Program for Recovery and Community Health at the Yale University School of Medicine in which peer staff were deployed as "recovery mentors" for individuals with SMI and a recent history of multiple hospitalizations resulted in statistically significant reductions in the number of days individuals spent in the hospital as well as decreases in depression and increases in hope, self-care and sense of well-being.⁶⁸

Where peer support programs have been introduced within state hospitals, it is often on a limited basis. One example of a more extensive inpatient peer support program is at Maine's Riverview Psychiatric Center, where peer support specialists are involved in all stages of patient care, from admissions to attendance at treatment team meetings at the patient's request. Peer Support Specialists are assigned to each of the four units of the

⁶⁶ Martz, Erin, PhD. and Newbill, Will, PhD. "The Rehabilitation of a Hospital: The Transformation of a State Psychiatric Hospital." *The International Journal of Psychosocial Rehabilitation*. Vol 18(2) 89-100. 2014.

⁶⁷ Oregon 2015 Mental Health National Outcome Measures (NOMS); SAMHSA Uniform Reporting System. <http://www.samhsa.gov/data/sites/default/files/Oregon.pdf>

⁶⁸ Davidson, Larry et al. "Peer Support Among Persons with Severe Mental Illnesses: A Review of Evidence and Experience." Mental Health Policy Paper for the Program for Recovery and Community Health, Yale University School of Medicine. *World Psychiatry* 11:2. June 2012.

hospital, facilitate support groups and wellness and recovery classes and are involved in all major decisions within the hospital as part of the continuum of recovery-oriented care.

Forensic peer support is an emerging model that involves providing support from peers with a history of both mental illness and forensic inpatient involvement. The Community Living, Education and Recovery Program (CLEAR) is one such forensic peer-support program “designed to facilitate the earliest possible discharge and appropriate residential placement for forensic residents while simultaneously identifying and managing risk factors”⁶⁹. CLEAR is operated out of the Twin Valley Behavioral Healthcare Hospital (TVBH) in Columbus, Ohio, which serves approximately 200 civil, forensic and maximum security consumers of the Ohio Department of Mental Health (ODMH).

The forensic peer supporters within the CLEAR program consist of former forensic consumers within the TVBH treatment system who thus have a unique “firsthand experience” to help current forensic consumers both in navigating their time in TVBH and preparing for life outside the facility. In 2012 the peer supporter team was made of seven peer support specialist contracted for 20 hours a week and one peer support specialist for co-diagnosed substance abuse and mental illness consumers contracted for 10 hours a week. The team of eight peer supports is under the direction of the Clients Rights Advocate, the Acute Care Program Administrator, the SAMI Services Coordinator and the Community Support Network’s Clinical Director (TVBH, Peer Support Program).

Peer supporters are involved in each consumer’s recovery process, right from the start of a consumer’s entrance into the CLEAR program. Peer supporters have their own defined office space in the consumer care areas where they are able to greet all hospital admits with a description of TCBH’s peer support services. They attend all each consumer’s treatment and planning meetings to assist in the development of the consumer’s recover objectives and goals. They are also able to answer questions the consumers may have, but would feel uncomfortable asking other TVBH staff.

Along with these services, peer supporters serve five distinct roles:

- (1) Role models for risk free effective behaviors both in the hospital and on residential placement
- (2) Unique communicators between consumer and the professional staff during sensitive treatments such as trauma related care
- (3) Identifiers and innovators for improved consumer care procedures within the hospital culture and in the local, state and federal systems
- (4) Mediators during complaint or grievance resolutions between consumers and family members with hospital staff or community resources
- (5) Mentors and teachers for self-advocacy skills for the attainment of treatment, housing, education, employment and economic recovery goals

⁶⁹ Short, Robert, MA et al. “The Impact of Forensic Peer Support Specialists on Risk Reduction and Discharge Readiness in a Psychiatric Facility: A Five-Year Perspective.” *International Journal of Psychosocial Rehabilitation*. Vol 16(2) 3-10. 2012.

Initiate Formal Discharge Planning at Admission

Discharge planning is ideally a collaborative effort among parties including the patient, his or her treatment team, other hospital staff and those who will have some responsibility for the care of the patient at discharge. Effective discharge planning is best initiated at the time of admission and in this is recognized by the fact that state hospital discharge guidelines generally require this as standard practice. That said, the elements of discharge planning are not always standardized nor the parties involved.

The patient and his or her unique needs and preferences must be at the center of the discharge planning process. Cultural and linguistic competency in discharge planning is frequently cited in guidance as a determinant of successful discharge planning and thus early identification of the need for translators, peers or other individuals who can help address and work through communication barriers is of utmost importance. The treatment team - which may include the psychiatrist, psychologist, counselor, social worker, case manager, peer specialist and others - will play a major role in developing the discharge plan. Beyond that, other parties that may be appropriate for participation include relatives and friends, external peer support specialists and representatives from community programs and agencies that will or might play a role in supporting the client's healthcare or other needs in the community at discharge.

Certain conditions or circumstances may pose particular barriers to successful discharge; among these are the presence of co-occurring disorders requiring more complex care, behavioral problems, individuals living in poverty and those lacking family, friends or other support persons nearby that can participate in the discharge planning process and help support a successful transition to the community.

Federal guidance related to psychiatric discharge planning is limited although guidelines issued by the U.S. Department of Health and Human Services' Medicare Learning Network in 2014 note that the process should address anticipated problems after discharge and suggested means for intervention, including: accessibility and availability of community resources and support systems, including transportation; accessibility and availability of medications and counseling by a pharmacist; and special needs related to the patient's functional ability to participate in aftercare planning.⁷⁰

An increasing number of resources and programs focused on effective discharge planning, including specific to psychiatric hospitalization, are available to assist with designing or refining the process. One of the more widely praised models is the Re-Engineered Discharge (RED) program developed at Boston University Medical Center and adapted into a toolkit for the Agency for Healthcare Research and Quality (AHRQ.) The toolkit addresses the essential elements of successful discharge planning from the point of admission until well after discharge and offers step-by-step instructions for introducing new discharge planning processes to staff and patients, implementation and outcome measures and tools to be in used in conjunction with patients as part of the process. RED meets Joint Commission standards, is endorsed by CMS and has shown proven results in reduced hospital readmissions and emergency room visits.⁷¹

Specific to transitions in psychiatric care, the 2012 study "Care Transition Interventions in Mental Health" identified nine key themes from an extensive review of intervention models for individuals with behavioral

⁷⁰ "Discharge Planning." U.S. Department of Health and Human Services Learning Network. ICN 908184. October 2014

⁷¹ Jack BW, Paasche-Orlow MK, Mitchell SM, et al. An overview of the Re-Engineered Discharge (RED) Toolkit. (Prepared by Boston University under Contract No. HHSA290200600012i.) Rockville, MD: Agency for Healthcare Research and Quality; March 2013. AHRQ Publication No. 12(13)-0084.

health needs: prospective modeling, patient and family engagement, transition planning, care pathways, information transfer/personal health records, transition coaches/agents, provider engagement, quality metrics and feedback. While addressing broader considerations, the model contains many components that have clear implications related to discharge planning and is designed to ensure that care and support for the needs of psychiatric patients is as effective as possible prior to, during and after hospitalization.

Standardized Data Collection Related to Discharge

Another challenge related to discharge planning and follow-up is the lack of standardized data collection at the time of discharge and thereafter. Such standardization can assist both the discharging facility and the client in tracking client disposition, resource referrals, treatment and medication requirements and enabling better planning for and analysis of patient needs and profiles. A “Best Practices Manual for Discharge Planning” published by the Los Angeles Coalition to End Hunger and Homelessness identified the following suggested standard data elements for collection by mental health entities at the time of patient discharge:

- Reason for discharge
- Mental health/substance abuse treatment and service needs at discharge
- Services provided to client while in the care of the discharging entity
- Primary or significant problems/issues identified during the treatment stay
- Assessment of client level functioning
- Referrals provided for ongoing mental health and/or substance abuse treatment
- Referrals provided for “recovery support” type of services
- Primary agency to which individual is being discharged
- Other information related to client/patient’s achievement of treatment goals/outcomes

Standardized data collection components coupled with an information management system that enables real time information sharing across facilities and care settings can significantly increase the effectiveness of discharge planning and follow-up efforts to better track and meet the full range of patient needs.

Interconnected Health Records Across Systems

Data collection systems within behavioral health facilities have traditionally been known for lack of standardization and interoperability. Behavioral health providers have not had the same level of access to incentives for improving and streamlining data collection and reporting processes such as through the federal Electronic Health Record (EHR) incentive payment program for Medicare and Medicaid providers, creating barriers to accessing real time, meaningful information about patients that enables the timeliest and most appropriate care possible.

Within state-operated psychiatric facilities, the introduction and effective use of standardized EHRs is often particularly daunting due to considerations of cost, size of the facility/staff and often resistance to new systems. However, effective design and implementation of such systems will almost certainly result in improved efficiencies among staff and other stakeholders and better, more coordinated patient care. Common features of EHR implementation directly related to patient care include scheduling, physician orders, treatment/recovery planning, progress/case documentation, clinical assessments, exchange of patient information with providers and information about patient admission, discharge and transfer.

A 2014 presentation by the National Association of State Mental Health Program Directors (NASMHPD) Research Institute indicated that among states in the process of EHR implementation, frequently cited enhanced quality assurance, improved data reporting, improve productivity, reduced billing errors and the generation of client outcome measures.⁷² In a 2015 needs analysis, the Colorado Office of Behavioral Health cited development of a common management information system as a priority for exploration, acknowledging that this action would likely accelerate efforts to refine planning and delivery over the next several years, connecting various provider types and care settings across the state and collecting measurable and consistent quality and outcomes data. Another suggested benefit was the ability to gather information about individuals involved with multiple health and human service agencies and use predictive analytics to identify at-risk individuals that could greatly benefit from early interventions and supports.⁷³

Staff Training on Non-Medical Issues

Several of the issues identified in this section related to best practices or improvements in state hospital operations are dependent on the effective engagement and participation of hospital staff at various levels. For this reason, providing staff with sufficient training addressing targeted improvements and explaining the importance and intended effects of these changes is critical to their success. Training opportunities geared toward specific segments of the staff may include:

- recovery-oriented treatment principles and practices
- implementing effective discharge planning procedures
- anticipating and addressing patient concerns related to re-integration
- cultural competency to enable better patient-centered planning
- use of improved data collection tools and information systems

Meaningful and effective training of staff requires a significant investment of time and resources so assessing the need for level and type of training, identifying the requisite staff and designing engaging and informative training sessions and tools are vital to maximizing the impact and longevity of such training.

5.2. Role of Community Mental Health

The widely accepted principle that behavioral healthcare should be delivered in the least restrictive setting possible has driven tremendous investment in the community mental health system and the development and refinement of a huge array of services intended to address conditions and needs previously addressed primarily or exclusively in inpatient settings.

Although the community mental health system plays an elaborate and far-reaching role in the provision of healthcare and related services to individuals with behavioral health needs, the focus of this analysis is on best practices related to how the community-based system of care can best complement the state hospital system

⁷² “Implementation of Electronic Health Records (EHRs) by State Mental Health Agencies (SMHAs.)” Presentation by NASMHPD Research Institute. January 28, 2014.

⁷³ Western Interstate Commission for Higher Education Mental Health Program. “Needs Analysis: Current Status, Strategic Positioning and Future Planning.” Conducted for the Colorado Department of Human Services, Office of Behavioral Health. April 2015.

and especially reduce the need for inpatient care at these facilities by successfully treating individuals in the community and diverting them from more intensive levels of care.

Implement Integrated Care Models for Early Identification and Intervention

Integration of behavioral health and primary care has been a topic of considerable focus in recent years and a broad array of related initiatives are underway at the state and local level, many of which are authorized by the Patient Protection and Affordable Care Act (ACA) and bolstered by significant federal funds for implementation. One of the more recent initiatives is the previously mentioned CCBHC program, which is currently in the planning stages in about half of the states. Although states have a fair degree of flexibility in defining the scope and parameters of certain services, the model includes a requirement that certified clinics provide primary care screening to behavioral health clients and reported on quality measures related to this. Participants for the demonstration phase of the program are expected to be selected by SAMHSA in late 2016/early 2017 and results from the demonstration phase are expected to inform possible rollout of a nationwide model based on best practices and outcomes from the participating states.

Accountable care organization (ACO) models are currently operating in many state Medicaid programs with the goal of improving care and reducing costs by paying providers for achievement of established goals and outcomes related to the provision of healthcare in lieu of the traditional fee-for-service model that paid for care based on volume of services. One of the more successful accountable care models is Minnesota's Integrated Health Partnerships (IHP) model, which delivered an impressive \$61.5 million in savings in 2014 and is expected to be expanded to include roughly half of the state's Medicaid enrollees by the end of 2018. Notable features of some provider group offerings include linking individuals who visit the emergency room with urgent outpatient mental health appointments, integrating mental health into primary care and providing care coordination to identify and address needs for housing, transportation and other support services. Additionally, several of the participating providers specialize in caring for people with disabilities.⁷⁴

Although harder to measure the direct impact of early integration of physical and behavioral health needs across the provider landscape, such integration is widely considered to be a best practice in the management of consumer health conditions and diversion from more intensive treatment levels and settings. As programs proliferate, outcome measures and quality metrics are refined and more data is collected and analyzed relative to these initiatives, information about best practices and proven models will be more widely available to states as they consider the design and expansion of current integrated care offerings.

Provide a Strong Network of Community-Based Interventions

Community-based crisis intervention and stabilization programs play a vital role in promptly addressing the treatment needs of individuals experiencing a behavioral-health related crisis and often result in an individual being successfully diverted from inpatient commitment. The Substance Abuse and Mental Health Administration (SAMHSA) has published a set of Practice Guidelines related to effective provision of crisis mental health services that include principles such as providing services that are trauma-informed and culturally appropriate in the least restrictive setting possible and ensuring that meaningful measures are taken to reduce the likelihood of future emergencies.⁷⁵ Crisis services are typically offered on a continuum ranging

⁷⁴ Bauer, Katie. "Minnesota's Medicaid Reform Initiative Saves \$61.5 Million in 2nd Year." DHS News Release. June 19, 2015.

⁷⁵ *Practice Guidelines: Core Elements in Responding to Mental Health Crises*. Substance Abuse and Mental Health Services Administration. SMA-09-4427. 2009.

from less intensive hotline and referral services to in-person interventions and short-term inpatient and/or residential care to stabilize individuals at risk for crisis in the community.

Crisis stabilization units (CSUs) are a common community-based alternative to hospitalization that typically involve 24/7 care and monitoring of an individual at risk of a mental health crisis until he or she stabilizes and is ready for release back into the community. Many community-based mental health providers operate CSUs with a limited number of beds and the typical length of stay is 3-7 days. A similar but less restrictive model is the respite center, a secure facility where an individual on the verge of a mental health crisis can go to take a break from the pressures of daily living and connect with peer professionals for support. Community Access in New York City is one such facility where adults referred by a mental health provider can come to stay for up to a week. The facility does not prescribe or administer medications and guests check in on their own and may come and go as they please. The cost of a respite center stay is a fraction of the cost of a hospital stay and may ultimately be more effective at preventing a psychotic episode. As of June 2015, the program had served approximately 700 individuals at four respite centers and the city's health department was planning to conduct an analysis to determine whether the program had resulted in a reduction in visits to psychiatric emergency rooms.⁷⁶

Mobile crisis teams represent one of the most aggressive forms of crisis services designed to address emergency behavioral health needs in a community setting. These teams of trained mental health professionals have the ability to meet the individual in crisis in the community and often within a brief period of time since they are typically on call 24 hours per day, seven days per week. Mobile crisis teams are often more challenging to implement in less populous areas due to more limited availability of on-call providers and a wider geographic area to cover.

Crisis Intervention Team (CIT) training is another critical component of an effective community mental health system due to its proven success in diverting individuals in crisis from jail and reducing re-arrests for those previously involved with law enforcement. In addition to enabling individuals in crisis to avoid arrest and possible incarceration or hospitalization, many studies have noted significant cost savings associated with investment in CIT training. A 2014 study of the costs and savings associated with implementation of a CIT program in Louisville, Kentucky noted that based on an average of 2400 CIT calls annually, overall costs of \$2,430,128 (officer training, hospitalizations, emergency psychiatric evaluations and arrests) were offset by savings of \$3,455,025 (deferred hospitalizations, reduced inpatient referrals from jail, avoided bookings and jail time), resulting in a net annual cost savings of \$1,024,897.⁷⁷

An emerging model of crisis care is the community crisis center, generally a large facility at which an individual with behavioral health needs may access an array of services in one place. One such example is the Common Ground Resource and Crisis Center in Pontiac, MI, which offers a full spectrum of crisis services funded by public and nonprofit sources in one location. Visitors are greeted by a receptionist who gathers information that is used by a triage clinician to determine those services for which the individual may be appropriate. Available services include resource and referral support for healthcare, counseling, legal and other services or access training, support groups or recreational activities. More intensive services include transitional living

⁷⁶ Vestal, Christine. "Respite Centers Offer a Way to Avoid Mental Health Crisis and the Hospital." *The Washington Post*. June 8, 2015.

⁷⁷ El-Mallakh, Peggy L., PhD et al. "Costs and Savings Associated with Implementation of a Police Crisis Intervention Team." *Southern Medical Journal*. Volume: 107 Issue: 6. JUNE, 2014.

arrangements for homeless young adults, youth crisis beds, crisis intervention and recovery services and a crisis residential program. A The center served over 64,300 individuals through fiscal years 2012 and 2013.⁷⁸

A similar program with a particular emphasis on jail diversion, Restoration Center in Bexar County, TX was opened in 2008 to provide a “one-stop shop” to provide treatment and services to individuals in crisis to prevent them from entering jails or emergency rooms. Services available onsite include a sobering unit, residential detoxification unit, crisis care center, minor medical clinic, opioid addiction treatment services, Mommies program for intensive substance use and a clinic offering primary care services to people receiving treatment or mental health and/or substance use disorders. The Center for Health Care Services, which operates Restoration Center, estimates that since its inception over 98,000 county residents have been diverted into treatment programs at an estimated taxpayer savings of more than \$50 million.⁷⁹

A 2014 report by the Substance Abuse and Mental Health Administration (SAMHSA) outlined opportunities and challenges associated with implementation of crisis services gleaned over several years of experience at the state level. Suggested opportunities for strengthening and sustaining operations included the use of peers as part of the crisis team and collaboration with entities including hospitals and emergency departments (ED) to reduce ED wait times and develop alternatives to ED utilization. The report also emphasized the importance of data collection on key indicators such as response time to calls and percentage of individuals diverted from inpatient hospitalization to improve crisis service delivery. Regarding funding, states including Massachusetts and Michigan have noted the effectiveness of using 1115 and 1915b waivers to embed these services.⁸⁰ Roughly half of the states have been awarded planning grants from SAMHSA to explore implementation of a Certified Community Behavioral Health Clinic model that would include development of a prospective payment model to reimburse for an array of services including crisis response and stabilization services.

As the population of the nation and Washington state is aging, it is important that adequate number of crisis beds also have the skills necessary to deliver assistance with personal care needs. Mental health crisis service providers do not often have the capacity to provide personal care assistance and, as a result, individuals who have a personal care need are either not served or are served in a medical hospital instead of community settings.

Beyond crisis services, the community mental health system also has a critical role in designing and managing other hospital and jail diversion strategies. One of the most promising, Assisted Outpatient Treatment (AOT) is designed to decrease violent behavior in individuals with SMI by requiring them to follow a court-ordered treatment regimen, typically involving medication, in exchange for being able to reside in the community. Recent statistics on the effectiveness of AOT note that it has resulted in:

- a 36 percent decrease in violent behavior after one year
- a 47 percent decrease in violent behavior (physically harming others) after six months
- a 66 percent decrease in “serious violent behavior” after one year

⁷⁸ Heincelman, Amy, LMSW et al. Presentation: “Community Crisis Center: An Urban Model.”

<https://www.macmhb.org/sites/default/files/attachments/files/Workshop%209%20Community%20Crisis%20Center%20MACMHB%20Presentation%20thumb.pdf>

⁷⁹ Evans, Leon. “A Continuum Alternative to Prisons and ERs.” *National Council Magazine*. Issue 1, 2016.

⁸⁰ *Crisis Services: Effectiveness, Cost-Effectiveness and Funding Strategies*. Substance Abuse and Mental Health Services Administration. HHS Publication No. (SMA)-14-4848. Printed in 2014.

- reduction in the chances of being arrested for a violent offense by 88%

Conditional release resulted in an 80 percent decrease in violent behavior after two years.⁸¹

Closely related is Assertive Community Treatment (ACT), a longstanding evidence-based practice that improves outcomes for people with SMI who are most at-risk of homelessness, psychiatric crisis and hospitalization and involvement in the criminal justice system. ACT is a multidisciplinary team approach with assertive outreach in the community to develop consistent, caring, person-centered relationships with people with SMI to improve outcomes and quality of life. With a particular focus on individuals being released from inpatient care, including as part of conditional release programs, ACT is widely considered to facilitate deinstitutionalization and enable successful community reintegration of individuals with SMI and has proven to be strongly effective and cost-effective for clients who returned repeatedly to psychiatric hospitals.⁸²

A recent study highlighted several of the key principles considered to form the foundation of an effective ACT program, including: in vivo assessment, training and support; assertive outreach; holistic approach; multidisciplinary team; direct service model; integration of services; low staff-client ratio; continuous coverage; and long-term and continuous care. Also emphasized, however, is the inherent flexibility of the ACT model to be adapted to a variety of audiences and individual needs and examples of this include ACT programs specifically geared toward clients with substance abuse treatment needs, early episodes of psychosis, borderline personality disorder and criminal justice histories.⁸²

Provide Effective Care Transition Support for Discharged Patients

The community mental health system plays a critical role in providing care coordination and follow-up with individuals being discharged from state hospitals. The timeliness, nature and intensity of this support can have a tremendous impact on the individual's adherence to components of the discharge plan related to follow-up treatment and medication therapy and may significantly impact whether the individual requires readmission for inpatient psychiatric care in the future.

A 2015 assessment report from the NASMHPD notes that the provision of care transition support to individuals being discharged from inpatient psychiatric care holds significant promise for averting re-hospitalizations among this population. Unfortunately, limited research has been performed on interventions across transitions of care for individuals with mental illness including those transitioning from inpatient to outpatient care. In fact, the only nationally recognized comprehensive model to which the report points is the Availability, Responsiveness and Community (ARC) model, which focuses on preventing children and adolescents from entering the next most intensive or restrictive level of mental health treatment.⁸³

During the period directly following hospitalization individuals with serious mental illness (SMI) are at risk of relapse, homelessness and violent behavior or suicide, as well as hospital readmission.⁸³ A significant majority of hospital stays for mood disorders and schizophrenia result in a discharge disposition of home or self-care (89 percent and 78 percent, respectively),⁶³ underscoring the need for community-based follow-up with individuals being discharged from inpatient care for psychiatric disorders. The NASMHPD report notes that

⁸¹ "Does Assisted Outpatient Treatment (AOT) Decrease Violence?" Treatment Advocacy Center Backgrounder. Updated 6/2016.

⁸² Bond, Gary R. and Drake, Robert E. "The Critical Ingredients of Assertive Community Treatment." *World Psychiatry* 14:2. June 2015.

⁸³ Pincus, Harold, MD. "Assessment #3: Care Transition Interventions to Reduce Psychiatric Re-Hospitalizations." National Association of State Mental Health Program Directors. September 15, 2015.

although individuals with SMI are expected to have a follow-up outpatient visit within a week of hospital discharge, reports from the National Committee for Quality Assurance indicate that only about 40 percent of Medicaid and Medicare recipients receive that follow-up.⁸³

Acknowledged as a best practice for serious mental illness (SMI) by Medicaid Health Plans of America, Wellpoint Indiana's Behavioral Health Follow-up After Hospitalization program is designed to address barriers to accessing outpatient treatment among individuals following an acute psychiatric hospitalization. This approach involves teams focused on utilization management, intensive case management and outreach care working collaboratively to address the needs of individuals beginning at the time of admission into acute psychiatric care and carrying over into follow-up activities during and after discharge. The utilization management team works with the hospital to begin discharge planning at the time of admission. Once the individual is discharged, an Outreach Care Specialist contacts the individual within two business days to explain the importance of following the discharge plan and attending scheduled appointments; the specialist will make additional calls to remind the individual of the appointment and to follow up if an appointment is missed.

Also, for individuals with significant barriers who cannot see a mental health provider within seven days of discharge, a "transition session" can be provided on the day of discharge to review and discuss adherence to the discharge plan and medications and address anxieties and potential barriers to compliance with the discharge plan. Another component of the program is provider education about the importance of after-care follow-up with discharged patients. Success of the program is measured via both programmatic and national indicators, notable among which is an increase in the percentage of members who kept a follow up appointment in seven days, from 48.20% in 2009 to 73.66% in 2010, the first full year after implementation of the transition appointment.⁸⁴

Other state-specific examples of discharge planning coordination programs that have demonstrated measures of success in recent years include Oregon's Care Choices Model and the Reducing Avoidable Hospital Readmissions Effectively (RARE) campaign in Minnesota. One other promising initiative is the Center for Medicare and Medicaid Services' Innovation's (CMMI) Community-Based Care Transitions Program, which provides funding to hospitals with high readmission rates to test models of coordinated care for high risk Medicaid beneficiaries. The goals of the program are to reduce readmission rates and improve patient experience with transitions of care. Although psychiatric hospitals are currently not eligible to participate in the program, some of the demonstrations underway include coordination with community-based mental health providers to address the needs of individuals with a mental health and/or substance use disorder condition.

Collaborate with Wraparound and Support Service Providers

Collaboration at the community level to address consumer needs beyond treatment for behavioral health conditions is another cornerstone of effective community-based care. As well documented, a significant percentage of individuals with behavioral health needs, particularly acute needs, face barriers to finding and maintaining stable housing, employment, education and other resources that are key determinants of successful community integration.

⁸⁴ Greenberg, Liza, RN, MPH, MHPA. *Medicaid Health Plans of America Center for Best Practices: Best Practices Compendium for Serious Mental Illness*. 2012.

One of the most frequently cited barriers to releasing discharge-ready patients from state psychiatric facilities is a lack of appropriate community-based placements for the individual. Although a particular challenge for forensic patients due to frequent need for placements with security features and community concerns about safety, placements can be similarly difficult for patients being released from civil commitment. A 2013 Virginia analysis of barriers to discharge from state hospitals indicated a host of interconnected challenges related to effective community placement including: need for housing or intensive/supervised residential services, forensic or NGRI legal status, extensive behavioral health needs and major medical conditions/chronic health problems.⁸⁵

Unfortunately, there are no easy answers to the question of placements for discharged individuals although community-based providers have traditionally found creative ways to address these needs at the local level through intensive coordination with local and county governments, state agencies, nonprofits, payers and others to address the particular needs of a community, although lack of funding is a persistent challenge. In many cases, managed care programs have enabled community providers to have greater flexibility in using limited resources to address consumer need for support services in a manner appropriate to the region and populations served.

A prominent example of a successful support program is Housing First, an international model that provides permanent housing to people experiencing homelessness and has a particular focus on individuals and families with mental health or substance use disorders who have experienced long-term or repeated homelessness. Housing First programs are operational in communities across the country and have proven highly successful in addressing both long- and short-term housing needs of clients served, including a retention rate of up to 98% for permanent supportive housing and between 75-91% retention of rapid re-housing designed to help individuals exit homelessness quickly.⁸⁶ Other studies have shown improvements in impairment related to mental health, substance use and co-occurring conditions, better adherence to psychiatric medication regimens and improved money management.

5.3. Funding the Mental Health System

As discussed in previous sections of this report, Medicaid funding, including associated Disproportionate Share Hospital (DSH) funding, provides an important revenue source for mental health services. The following section provides a review of ways in which Medicaid and DSH funding are impacted by changes to the structure of a state's mental health system and strategies that have been employed nationally to mitigate such impacts.

Reimbursement for Forensic Services in State Psychiatric Hospitals

Medicaid Revenue (Fee for Service, MCO or DSH) funding is not available for those individuals who are involuntarily in secure public institutions as a result of criminal charges. This may include a direct transfer from a correctional setting for observation and stabilization, those ordered by the court system for a

⁸⁵ Morehart, Michael F.A. Virginia Department of Behavioral Health and Developmental Services Discharge Assistance Program Performance Review. OSIG Report Number 2014-BHDS-005. February 2014.

⁸⁶ Fact Sheet: Housing First. Questions and Answers on Homelessness Policy and Research. National Alliance to End Homelessness. www.endhomelessness.org.

psychiatric evaluation, those found incompetent to stand trial and those found Not Guilty by Reason of Insanity (NGRI).

The Social Security Act (1905 (A)(a)) specifically precludes medical assistance (Medicaid) "...with respect to care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution)." Additionally, 42 CFR § 435.1008(a)(1) states that Federal Financial Participation (FFP) is not available for services to "individuals who are inmates of public institutions as defined in Sec. 435.1009." In turn, 42 CFR § 435.1009 defines an inmate of a public institution as, "... a person who is living in a public institution. An individual is not considered an inmate if – (a) He is in a public educational or vocational training institution for purposes of securing education or vocational training; or (b) He is in a public institution for a temporary period pending other arrangements appropriate to his needs."

When determining whether FFP is prohibited under the above noted statute, two criteria must be met. First, the individual must be an inmate; and second, the facility in which the individual is residing must be a public institution. An individual is an inmate when serving time for a criminal offense or confined involuntarily in State or Federal prisons, jails, detention facilities or other penal facilities. An individual who is voluntarily residing in a public institution would not be considered an inmate and the statutory prohibition of FFP would not apply.

Recent federal Office of the Inspector General (OIG) audits have targeted Medicaid payments for forensic individuals in state psychiatric facilities.⁸⁷ In most of these cases, IMD-DSH reimbursement was being claimed for bed days and costs associated with the forensic population. Reports cited in the footnotes of this subsection identify the audit and recommended dollar recovery for Maine, Missouri and Pennsylvania State Operated Psychiatric Facilities.

IMD-DSH Considerations for Washington State

Federal financial participation (FFP) is not available for Medicaid services for individuals between the ages of 21 and 64 who are patients in an Institution for Mental Disease (IMD). This IMD exclusion is a long-standing component of Title XIX (Grants to States for Medical Assistance Programs) of the Social Security Act (Title XIX). However, FFP is eligible for Medicaid disproportionate share hospital (DSH) payments to these IMD facilities.

The Medicaid disproportionate share hospital (DSH) payments are statutorily required payments intended to offset hospitals' uncompensated care costs to improve access for Medicaid and uninsured patients as well as the financial stability of safety-net hospitals. IMD-DSH reimbursement is eligible to IMD facilities based on an annual cap established in the federal register. Under federal law, 42 USC 1396r-4(h)(2), the state's annual IMD DSH expenditures are capped at 33% of the state's annual statewide DSH cap. This amount represents the maximum the state can spend in any given fiscal year on IMD DSH.

Washington has a preliminary 2016 IMD DSH Allotment of \$66,348,199 (and a total DSH Allotment cap of \$201,055,149). Washington's regulations stipulate that IMD DSH is only available to "state owned and

⁸⁷ State of Maine OIG Audit - <https://oig.hhs.gov/oas/reports/region1/10900011.pdf>

State of Missouri OIG Audit - <https://oig.hhs.gov/oas/reports/region7/70603086.pdf>

Commonwealth of Pennsylvania OIG Audit - <https://oig.hhs.gov/oas/reports/region3/30100221.pdf>

operated psychiatric hospitals—Eastern and Western State Hospital” (WAC 182-550-5130: Institution for Mental Diseases DSH (IMDDSH)).

The Patient Protection and Affordable Care Act (ACA) of 2010 reduced federal DSH allotments nationally, which had been about \$11 billion annually, to account for the decrease in uncompensated care anticipated under health insurance coverage expansion. As enacted in the ACA, the DSH allotment reductions would have ended after fiscal year 2020 and allotments would have reverted to their pre-ACA levels. However, several pieces of legislation have been enacted since 2010 that have altered the ACA’s Medicaid DSH reduction schedule. The most current change was enacted by the Medicare Access and CHIP Reauthorization Act of 2015 and eliminated the fiscal year 2017 reduction, which delayed the reductions until fiscal year 2018, adjusted amounts of reductions in future years and extended them to fiscal year 2025. As a result, the current schedule and amounts for the Medicaid DSH reductions are as follows:

- \$2.0 billion in fiscal year 2018
- \$3.0 billion in fiscal year 2019
- \$4.0 billion in fiscal year 2020
- \$5.0 billion in fiscal year 2021
- \$6.0 billion in fiscal year 2022
- \$7.0 billion in fiscal year 2023
- \$8.0 billion in fiscal years 2024 and 2025

Washington will experience a significant DSH reduction without government intervention. DSH and IMD-DSH will decrease by approximately 10 percent a year starting in 2018. By fiscal year 2024 the maximum claimable IMD-DSH would be \$18M (compared to the current IMD-DSH limit of \$66M).

Implementation of IMD Medicaid “in-lieu of” regulations

The final Medicaid managed care regulations (final rule) clarify the use of IMDs as an “in lieu of” service. In the near term, states will need to carefully weigh their options based on their specific needs for inpatient psychiatric capacity. The risk is that adding too much inpatient capacity could induce utilization and drive members away from community-based alternatives. Section 438.6(e) of the final rule clarifies that states can receive FFP and make a capitation payment on behalf of an enrollee that spends part of the month as a patient in an IMD if the following conditions are met:

The provision of this service must meet the four following conditions for “in lieu of” services, as stated in Section 438.3(e)(2).

- The state determines that the alternative service or setting is a medically appropriate and cost-effective substitute for the covered service or setting under the state plan.
- The enrollee is not required by the managed care organization (MCO), prepaid inpatient health plan (PIHP) or prepaid ambulatory health plan (PAHP) to use the alternative service or setting.
- The services are authorized and identified in the MCO, PIHP or PAHP contract and will be offered to enrollees at the option of the MCO, PIHP or PAHP.

- The utilization and actual cost of "in lieu of" services is taken into account in developing the component of the capitation rates that represents the covered state plan services.

The facility must be a hospital providing psychiatric or substance use disorder inpatient care or a subacute facility providing psychiatric or substance use disorder crisis residential services. The length of stay cannot exceed 15 days during a given month (capitation payment period). IMD utilization may be included in the development of a managed care capitation rate, but utilization must be priced at the cost of same services included under the state plan.

Leveraging Alternative Models of Care through 1115 Waivers

Tennessee (TN) and Hawaii (HI) included all of their DSH and IMD-DSH allotments for fiscal years 1998 through 2002 based on 1115 waivers CMS approved. The intent was for TN & HI to include comprehensive funding in their managed care capitation payments. Implementation of such an option by a state requires broad examination of its existing state plans and/or waivers to determine feasibility.

IMD License Wrap

IMD-acute hospital license wraps may be used as long as the hospital can be certified by CMS as a single organization per 42 CFR 413.65 and the IMD patient percentage of less than 50 percent. For many states, this model presents an opportunity to more fully leverage federal funding for services since federal Medicaid limitations currently prohibit claiming for all individuals age 21-64 with Medicaid in the psychiatric facility. The conversion to a general acute care hospital with a capacity to serve mental health clients provides access to funds that are not currently available because of Institutions for Mental Disease (IMD) restrictions.

An IMD license wrap integrates the physical and psychiatric systems of care between these two facilities. More importantly, contracting with an acute care hospital may increase the collaboration of services for both mental and physical health, creating a more efficient service system.

16 Bed - Community Mental Health Centers

Mental health centers of 16 beds (or less) are not held to the Institutions for Mental Disease (IMD) Medicaid billing restrictions per section 1905(i) of the SSA. The IMD Medicaid billing restrictions restrict the Medicaid billing of inpatients to individuals below the age of 21 and above the age of 64. The building or purchasing of 16 bed (or less) mental health centers in a state can create an opportunity to bill Medicaid for the 21- through 64-year old population and potentially help to manage lost IMD-DSH revenue.

Psychiatric Bed Replacement Units

Contracting for psychiatric beds at private facilities (acute hospitals with psychiatric units and stand-alone psychiatric hospitals) is another way in which states have sought to manage costs associated with the provision of inpatient psychiatric care. In the late 1990s, Massachusetts closed several state operated psychiatric facilities and contracted with a dozen hospitals for psychiatric beds. This closure allowed the state to reduce the average state-operated bed census by 50%.

IMD-DSH Considerations Summary

If Washington adapts the IMD bed capacity and builds up community based services, the potential reimbursement for IMD-DSH may also decrease. In a changing system with limited funding, it is imperative that Washington develop a strategy which maximizes funding for behavioral health services for both state and community based resources. Any reduction in IMD-DSH should be offset by full Federal Medicaid Assistance Percentages (FMAP) for community based Medicaid eligible services, as long as the scope of community based services is equal to or less than the cost of services in the IMD facility. In addition, the state may have an opportunity to use the IMD-DSH cap space to fund other IMD facilities and/or Acute DSH Hospitals for indigent care. The net financial impact of the IMD DSH reduction should be limited in Washington as a) reductions in DSH are already incorporated into the federal strategy since the passage of the ACA, and 2) community based mental health services will not be subject to the IMD exclusion as the services are not being provided in an “Institution for Mental Disease”. Further financial and utilization modeling would need to occur once the program strategy for bed reduction and/or increased community based services is defined.

5.4. Resources for Civil Commitment

As Washington considers making changes to its bed allocation methodology to further incentivize behavioral health organizations to create and improve treatment diversions, two national best practices may prove applicable, as described below:

- Incentive payments may be structured into managed care contracts in a variety of ways. Many states have used Medicaid managed care contracts to incentivize service outcomes through bonus payments. For example, Wisconsin has previously used managed care bonus payments to increase vaccination rates among children. While many examples in the current Medicaid landscape center on physical health and prevention, the current national focus on behavioral health and integration suggests that many more examples of behavioral health related outcomes payments will be implemented in the coming years. Under Medicaid managed care, up to 5% of the total capitation rate may be designated as bonus payments.
- Delivery System Reform Incentive Pool (DSRIP) Medicaid waivers are also providing funding incentives to create alternative care models designed to minimize psychiatric inpatient stays. New York’s DSRIP program has funded local Performing Provider Systems to enhance crisis stabilization services for behavioral health as a strategy to reduce psychiatric hospital admissions.

As Washington applies for its own DSRIP waiver, the local Accountable Communities of Health may consider how to incentivize BHOs to further reform care practices. Thus, bed day capitation rate setting methods are not the only way to create new and better incentives for BHO hospital care diversion programs. Such alternatives may prove less complicated and more capable of facilitating change than rate formulas.

The current bed allocation methodology is authorized at RCW 71.24.310 and has three major components.

1. The methodology used to calculate the specific beds allocated to each behavioral health organization (BHO) is based on RCW 71.24.310(3) which states “The primary factor used in the allocation shall be

the estimated number of adults with acute and chronic mental illness in each behavioral health organization area, based on population-adjusted incidence and utilization.”

2. The language further goes on to state at RCW 71.24.310(6) “If a behavioral health organization uses more state hospital patient days of care than it has been allocated under subsection (3) or (4) of this section or than it has contracted to use under subsection (5) of this section, whichever is less, it shall reimburse the department for that care...”
3. Finally, the language RCW 71.24.310(7) states “One-half of any reimbursements received pursuant to subsection (6) of this section shall be used to support the cost of operating the state hospital and ...The department shall distribute the remaining half of such reimbursements among behavioral health organizations that have used less than their allocated or contracted patient days of care at that hospital, proportional to the number of patient days of care not used.”

In summary terms:

1. The method used to calculate the beds allocated to BHOs has to include the prevalence of mental illness and utilization.
2. The BHO has to pay for bed use over its allocation.
3. The payments are split evenly between the hospitals and the BHOs that did not exceed their bed allocation.

Implementation of the Statutory Language

The language at RCW 71.24.310(3) states that “The primary factor used in the allocation shall be the estimated number of adults with acute and chronic mental illness in each BHO area, based on population-adjusted incidence and utilization.”

PCG has obtained summary documentation describing how the allocation of beds is accomplished.⁸⁸ The allocation methodology has been implemented in four steps.

1. The first step uses a 2003 estimate of the number of individuals with serious mental illness (SMI) and then adjusts the 2003 data based on the 2015 population. The estimated number of individuals with SMI in each BHO is divided by the total number of individuals with SMI. The result is that each BHO has been assigned a percentage that is then multiplied by the total number of state hospital beds to determine what percentage of the beds each BHO is allocated.

Step one is a self-contained calculation that results in an estimate of bed allocations based solely on SMI prevalence. If a BHO has 5 percent of the individuals with SMI in the hospital catchment area, then under this step, it would be allocated 5 percent of the hospital beds.

⁸⁸ This is an undated document titled “Explanation of Calculation for Eastern and Western State Hospital Beds.”

- The second step calculates each BHO's recent utilization of beds and arrives at a "bed need" for each BHO by dividing the utilization by the estimated number of individuals with SMI in the BHO region as developed in step one. This bed need is converted to a "relative bed need" by dividing a BHO's per-capita bed need by the average per-capita bed need of all BHOs. This is the most difficult step to intuitively follow.

The product of step two is a series of weights. The initial number calculated is a measure of current bed use divided by the SMI prevalence. This ratio is calculated for each BHO and each resulting ratio is divided by the sum of all ratios. The result is a series of weights based on utilization that add to zero since they are calculated by subtracting each ratio from the mean average of all ratios.

- The third step calculates the bed allocation by multiplying the BHO SMI prevalence percentage from step one by the utilization weights of step two. Mechanically, the BHO SIM percentages from step one add up to a hundred percent and the utilization weights balance to zero so the result is a weighting of the SMI percentages which are then multiplied by the hospital's total bed capacity to arrive at a bed allocation for each BHO.

The third step results in a second calculation of the bed allocations for each BHO.

- The fourth step splits the difference between the two calculations and results in the bed allocation used by the state.

RCW 71.24.310(2) also permits behavioral health organizations to "recommend to the department the number of state hospital beds that should be allocated for use by each behavioral health organization." As noted in Section 4.2, State staff indicated that this statutory provision has been used in the eastern part of the state. However, BHOs in the western region have not reached consensus on a recommendation, and thus the state has employed the methodology described in statute.

The application of applicable bed allocation methodologies in each region resulted in the following bed allocations for 2016.⁸⁹

Table 42. BHO Bed Allocations for Eastern State Hospital

BHO Name	Bed Allocations Effective 4/1/2016
North Central Washington BHO	27
Greater Columbia BHO	55
Spokane County Regional BHO	110
Eastern State Hospital Total	192

⁸⁹ PCG has confirmed that the total bed counts used in this allocation match civil bed census at the hospitals.

Table 43. BHO Bed Allocations for Western State Hospital

BHO Name	Bed Allocations Effective 4/1/2016	Bed Allocations Effective 7/1/2016
King County BHO	234	222
North Sound BHO	119	112
Salish BHO	33	32
Optum Pierce BHO	94	89
SW Washington FIMC	40	39
Thurston Mason BHO	34	33
Great Rivers BHO	33	30
Western State Hospital Total	587	557

Issues in the Calculation Methodology

There are three issues with the calculation methods used. The first is an apparent reliance on SMI prevalence estimates from a report published in 2003.⁹⁰ A look at the 2003 document containing these prevalence estimates indicates that the data are from the year 2000 and earlier. Updated statistics are available. The federal mental health and substance abuse agency, SAMHSA, provides substate estimates of SMI prevalence based on cumulative state samples of households.⁹¹ The substate regions were chosen by DSHS and implemented by SAMHSA. These regions are shown in Table 44 below.

Table 44. SAMHSA Substate Region Definitions, 2012 NSDUH

East 1	East 2	North 1	North 2	West 1	West 2
Adams Chelan Douglas Ferry Grant Lincoln Okanogan Pend Oreille Spokane Stevens Whitman	Asotin Benton Columbia Franklin Garfield Kittitas Klickitat Walla Walla Yakima	Island San Juan Skagit Snohomish Whatcom	King	Kitsap Pierce	Clallam Clark Cowlitz Grays Harbor Jefferson Lewis Mason Pacific Skamania Thurston Wahkiakum

SAMHSA's prevalence rates for serious mental illness (SMI) by substate region are shown in Table 45.⁹²

⁹⁰ See <https://www.dshs.wa.gov/sites/default/files/BHSA/dbh/documents/2003Prevalence.pdf>

⁹¹ See <http://www.samhsa.gov/data/sites/default/files/substate2k12-RegionDefs/NSDUHsubstateRegionDefs2012.pdf>

⁹² See <http://www.samhsa.gov/data/sites/default/files/substate2k12-StateTabs/NSDUHsubstateStateTabsWA2012.htm> Table 48.10

Table 45. SAMHSA 2010-2012 Estimates for Serious Mental Illness by Washington Substate Region.

State and Region	SAMHSA Estimates
Washington	5.39
East 1	6.45
East 2	5.31
North 1	4.97
North 2	4.37
West 1	6.04
West 2	6.24

A comparison of the SAMHSA data for 2010-2012 with the 2000 data contained in Table 2.8 of the 2003 publication shows the SAMHSA estimates are higher for all regional areas.⁹³

A second issue in the calculation of the bed allocations is that it is not clear that the statutory language of RCW 71.24.310 has been carried out. RCW 71.24.310(4) reads “The allocation formula shall be updated at least every three years to reflect demographic changes and new evidence regarding the incidence of acute and chronic mental illness and the need for long-term inpatient care.”

The concept of “need” is imperfectly measured by assuming that current utilization equals need. It is likely that lower utilization does not imply less need, but rather higher unmet need or insufficient treatment capacity. Although population updates are incorporated into the methodology, there is no reference in the bed allocation methodology documentation that the incidence of acute and chronic mental illness or the unmet need for long-term inpatient care has been considered.

Consider the following policy example. A new managed care company is now assuming responsibility for behavioral health in a fully integrated service area. Its social workers find examples of individuals that have unstable or unsafe community placements. After a process of involuntary commitment these individuals are placed on an admissions list to the state hospital and are accepted for admittance. There are data showing that something like this happens now. DSHS data indicates that persons who have a prompt initiation of outpatient treatment tend to have higher readmission rates to state hospitals.⁹⁴ The number of bed days used by the managed care company will now increase and potentially the company could incur a “reimbursement change”, i.e. a financial penalty for exceeding its allocation. The result is that the company has to make a financial payment because its social workers provided a better identification of need and a more appropriate placement for the individuals.

A third issue is the use of the implicit assumption that all bed days associated with a hospital come from BHOs nearest the hospital. A mapping of zip codes from patients at Western State Hospital show that some come from the Moses Lake area, Okanogan and even Spokane.⁹⁵ Although migration creates minor distortions it probably has the greatest effect on the larger BHOs since individuals from out of their catchment area could

⁹³ This comparison is based on a comparing the ratio of the 1998 PEMINS data to total population to the SAMHSA prevalence estimates.

⁹⁴ See DSHS RDA report Quality Indicators and Outcomes for Persons Discharged from State Psychiatric Hospitals Table 4 Retrieved on 9-25-2016 from <https://www.dshs.wa.gov/sites/default/files/SESA/rda/documents/research-3-41.pdf>

⁹⁵ Eastern State Hospital did not supply zip codes of its residents.

move to obtain services. When daily penalties are \$600 dollars a day, even minor distortions due to migration will have financial results. Transfer agreements in place under RCW 71.24.845 may mitigate migration effects.

Stakeholder Comments

During interviews, stakeholders expressed two major comments:

First, the BHOs have only partial control over admission and discharge decisions. Although BHOs can and do implement diversion activities, it is the courts that decide who should be involuntarily detained. Although BHOs can work to secure community residences and services for individuals being diverted from admission and individuals being discharged, hospital staff have the ultimate say in who can be admitted and discharged and when.

Second, the BHOs cannot control the numbers of individuals that change their status from forensic to civil. These status changes, referred to as “forensic flips,” happen without the knowledge of the BHOs yet the days are counted against the BHO bed allocation. Data on these status changes indicates that during fiscal year 2015 approximately three and a half individuals per month “flipped” from forensic to civil at Eastern State Hospital and eight individuals per month flipped at Western State Hospital.

In addition, another issue raised by stakeholders was having to pay for using bed days beyond an allocation when the total bed days used by all BHOs was below the total bed days available. This matter was raised in a 2010 King County publication which pointed out that the County had paid \$2.5 million in payments even though the total BHO allocation for Western State Hospital had not been exceeded.⁹⁶

In calendar year 2015, approximately \$1,229,000 in payments were incurred by five BHOs. An examination by quarter shows considerable variation indicating that the BHOs are subject to fluctuations they may not be able to control. As a result of the allocation methodology, the hospitals received half the \$1,229,000 and the six BHOs that did not exceed their bed allocation received the other half of the \$1,229,000. The result of being fined \$1,229,000 means the five BHOs had to ask their county(ies) for more money, cut staff or other expenses, reduce services to individuals, reduce rates to providers, or use reserves.

Policy Considerations

The apparent intent of RCW 71.24.310 is to control the utilization of state hospital beds by BHOs and prevent over utilization by using financial penalties. Given this policy intent, the current bed methodology appears to be an imperfect instrument. Moreover, data or research showing the effectiveness of the policy is not readily available despite a long series of studies on Washington’s behavioral health programs.

The policy equates need with utilization, an association that omits unmet need. The policy penalizes efficient BHOs that lower their utilization because, as implemented, BHOs that lower their utilization have their bed allocations lowered. Moreover, the current bed allocation procedure is tantamount to providing free days and is not a stimulus for organizations to use the allocated days wisely in a cost effective manner.

⁹⁶ See http://www.kingcounty.gov/healthServices/MHSA/Legislative/~/_media/health/mentalHealth/2010_statehospital.ashx

Given the current policy, the rational financial strategy a BHO might consider is to maximize the use of its bed allocation up to the limit of the allocation. By following this procedure year after year, it is likely its allocation will be raised thus providing the BHO a measure of protection in years when utilization or forensic flips may spike unexpectedly.

There are three main policy choices:

- First, the existing system of bed allocations could remain and as fully integrated care is phased in managed care companies would be asked to assume the same methodology of risk as the BHOs currently assume. This approach would “carve out” state hospitals from the FIMC services for which the plans are capitated.
- Second, the adult psychiatric population could be brought into managed care and their state hospital utilization could be capitated.
- Third, individuals who are clients of the Developmental Disabilities Administration (DDA) and the Aging and Long-term Support Administration (AL TSA) could be brought under capitation. This approach would put the DSHS administrations at risk for the hospital utilization.

Given the impending changes to the BHOs with the advent of fully integrated managed care in 2020, there is a policy rationale for delaying a capitation of state hospital utilization services and implementing it with the managed care plans rather than the current BHOs. Moreover, the concept of capitating the BHOs for state hospital utilization prior to 2020 has a financial policy component which hinders its adoption. Only 1 percent of BHO budgets are from local funds and 12 per cent are from general fund state dollars.⁹⁷ It is likely that some of the individuals who use the beds that are over the allocation allotment are not Medicaid eligible for state hospital services. Their care in the hospital cannot be claimed as a Medicaid expenditure and a transfer of payment from the BHOs to the hospital cannot be claimed as a Medicaid expenditure. Putting the BHO at risk of state hospitalization utilization thus implies a shift of state general funds from the BHO to the Hospital, a transfer of state funds from one public pocket to the other. It is not clear what savings to the state result from such a transfer.⁹⁸

The concept of shifting the responsibility for geropsychiatric hospital residents and individuals with developmental disabilities is useful to examine. To what extent should the DSHS agencies that customarily provide services to these populations be responsible for their use of bed days in the state hospitals? Implementation planning to explore the pros and cons of this approach could be started in a timely manner and adoption would likely require legislative or executive direction to the department. For example, it is likely that staff in these agencies would point out the same difficulties to which the BHOs allude. The agencies do not control admissions and discharges and do not have the psychiatric medical resources to make independent discharge decisions.

The process of capitating the current BHOs or fully-integrated managed care organizations can be specified in a methodology. Planning for capitating managed care programs for hospital utilization could begin immediately. The planning is likely a multi-year process since control over discharges is now in the purview

⁹⁷ Behavioral Health Finance 101. PowerPoint present by DSHS staff to Select Committee on Quality Improvement in the State Hospitals, September 12, 2016 p. 9

⁹⁸ With one exception, Optum in Pierce County, the BHOs are essentially public entities.

of hospital staff and managed care companies would likely be reluctant to accept full risk for hospitalization without controlling discharges and having more influence over admissions.⁹⁹

The methodology needed to implement these coverage policy options is not difficult to identify and entails the following steps:

- Policy work would need to be coordinated with managed care companies to explain how risk management and medical necessity policies would be implemented by the state.
- Educational work would need to be completed by hospital management with medical leadership of the hospital wards.
- Relevant stakeholder groups such as unions representing hospital workers would need to be consulted.
- Decisions on whether to make DSHS agencies responsible for hospitalization would need to be resolved by DSHS leadership.
- Historical data on the days associated with each BHO/managed care client need to be identified.
- Bed day utilization counts of geropsychiatric individuals and individuals with developmental disabilities could be collected from the state hospitals and be used in the pricing of potential capitation methods.
- Utilization trends for adult populations for a multi-year period need to be established and projected forward.
- Utilization trends for individuals with intellectual and developmental disabilities need to be collected and similarly analyzed.
- Utilization trends for individuals who are the responsibility of the Aging and Long Term Support Administration also need to be collected and similarly analyzed.
- The per member per month rate for adults, individuals with ID/DD, geropsychiatric individuals and other distinct groups of patients, “rate cells,” would need to be established.
- Actuarially sound capitation rates would need to be established.
- Budget transfers would need to be authorized from state hospital accounts to managed care and agency accounts.
- Automated management reporting and accounting systems would need to be changed.

The mechanics of implementing a different system of risk for state hospital beds are reasonably clear given Medicaid’s long history with capitated managed care. Specific implementation steps such as identifying bed day costs would take some time but are doable.¹⁰⁰ More problematical are the policy reactions of hospital staff, stakeholder groups and the leadership of state agencies as they wrestle with questions as to what happens to hospital staff and how a shift like this would affect their programs.

5.5. Behavioral Health Integration

The Centers for Medicare and Medicaid Services (CMS) amended Medicaid managed care regulations this year to permit reimbursement of Institutes for Mental Disease (IMD) funding as an “in lieu of” services to 21-64

⁹⁹ Discharges from the hospitals have to be approved by Courts and there is a separate layer of local approval in eastern Washington that was implemented after the escape of a forensic patient in 2009. The community anger over letting a murderscape created an additional review committee composed of public members set up under aegis of RCW 10.77.270.

¹⁰⁰ For example, cost information made available to PCG so far does not currently identify the state general fund cost of operating types of beds.

year olds under managed care capitation rate setting. “In lieu of” services are alternative treatments considered to be cost effective and medically necessary. The policy change applies to short term stays of no more than 15 days in a month. A single stay that stretches across two months is for 15 days of federal reimbursement for each of those months.

In the months since CMS released this rule final, no state experience has emerged yet that provides data on the percentage or amount of cost that can successfully be matched under this provision. But the change underscores CMS support for state efforts to more fully integrate physical and behavioral health. To assess Washington’s opportunity, data on the prevalence of short term IMD stays will need to be identified. PCG identified average length of stay data for this study, but that information did not include short term stay prevalence.

Two decision making processes have resulted in plans to fundamentally alter the way in which medical and behavioral health care are organized in Washington.

1. The first is a significant legislative action:

In 2013, the Legislature adopted two bills, Second Substitute Senate Bill 5732 and Engrossed Substitute House Bill 1519, which required the state to establish performance measures in its purchasing of medical and behavioral services.

Chapter 225, Laws of 2014 (Second Substitute Senate Bill 6312) was a broad, fundamental bill that contained a strong vision of what effective mental health and substance use programs should look like.¹⁰¹ The Bill stimulated the creation of Regional Service Areas for Medicaid purchasing and laid out the standards for the managed care of physical and behavioral health purchasing.¹⁰² SSSB 6312-2014 required the then existing Regional Service Networks to integrate mental health services with substance abuse services by April 2016 and on that date the RSNs were renamed BHOs.

The role of the state hospitals was left unchanged by the legislation and was only briefly described in Section 7 of it. “The eastern and western state hospitals shall operate as clinical centers for handling the most complicated long-term care needs of patients with a primary diagnosis of mental disorder.”

Section 8 of SSSB 6312-2014 further stated that “By January 1, 2020, the community behavioral health program must be fully integrated in a managed care health system that provides mental health services, chemical dependency services and medical care services to Medicaid clients.”

This provision effectively phased out existing behavioral health organizations since their mental health and substance abuse provider network will contract with the managed care organizations and their crisis and other administrative activities will also be contracted out or operated by a county-related entity. As might be expected, BHO staff interviewed by PCG had varying opinions about the phasing out of BHOs.

2. The second decision making process was obtaining federal support that could be used to implement SSSB 6312-2014.

¹⁰¹ For ease of discussion, this legislation is referred to as SSSB 6312 2014.

¹⁰² Text of the 6312 Bill is found at http://lawfilesexst.leg.wa.gov/biennium/2013-14/Pdf/Bills/Session%20Laws/Senate/6312-S2.SI_.pdf

In February of 2013, Washington created a plan called the Washington state Health Care Innovation Plan supported by a \$1 million planning grant from the federal Medicaid agency, the Center for Medicaid and Medicare Services (CMS). The 2013 grant was followed by a CMS award of \$64.9 million in December 2014 for four-year implementation support for the Innovation Plan.

Phasing in Full Integration

Responsibility for the integration of physical and behavioral health at the state level lies with the state Medicaid agency, the Health Care Authority (HCA). The HCA initiated the integration by identifying counties that wished to be an early adopter of FIMC and providing technical assistance to county officials and representatives of the existing BHO.

The phasing in of full integration began April 2016 in southwest Washington with the counties of Clark and Skamania. County commissioners made the decision for implementation. It is possible that their decision was influenced by their experience with events in Oregon just across the state border. Clark is across the border from the city of Portland and Clark residents would be familiar with Oregon's efforts and coverage.

HCA contracted with two managed care plans, the Community Health Plan of Washington (CHPW) and Molina Health Care of Washington (MHW) for physical and behavioral health services to Medicaid beneficiaries in the two counties. HCA also signed a contract with Beacon Health Options (Beacon) to provide a regional crisis service that were previously the responsibility of the BHO.

The Beacon contract is constructed in an administrative service organization (ASO) format. Beacon has signed subcontracts with the two managed care organizations. Beacon provides a potpourri of services that were administered by the state or the BHO which could be devolved onto the managed care contract including:

- Providing mental health crisis services, including a crisis hotline and a mobile outreach team.¹⁰³
- Administering the Involuntary Treatment Act for admissions related to mental health and substance use.
- Managing the administration of the Mental Health Block Grant (MHBG) and Substance Use Prevention & Treatment Block Grant (SAPTBG).
- Paying for inpatient and discretionary outpatient services to non-Medicaid individuals with incomes less than 220 percent FPL.¹⁰⁴
- Operating the Behavioral Health Ombudsman service.
- Managing the administration of the Criminal Justice Treatment Account (CJTA) funds and Juvenile Drug Court funds.
- Providing care coordination to assist individuals in enrolling in Medicaid, when possible.

Although the integration of physical and behavioral health is a substantive innovation, the change process has been implemented conservatively. Only existing managed care organizations were allowed to bid to become one of the two new FIMC entities. The network of behavioral health providers has not been changed nor

¹⁰³ Data from The System for Communicating Outcomes, Performance & Evaluation (SCOPE) indicates that approximately 13,800 persons statewide received crisis services in 2015 up from 12,600 in 2014

¹⁰⁴ Beacon is currently managing seven non-Medicaid admissions to Western State Hospital.

have the rates paid the providers been changed. The existing bed allocation methodology used for beds at Western State Hospital has also been retained.

Based on the percent of the population served, the three contractors were allocated a portion of Southwest Washington's 40 beds at the state hospital. Molina Healthcare was allocated 25 beds; CHPW eight beds; and Beacon Health Options received seven beds. Data from the first three months of operation indicates that, as a group, the contractors have admission rates below their state hospital bed allocations. Plan staff say they seek alternative beds both in the region and out of the region, e.g. in Oregon.

According to the FIMC contract at 5.18, the HCA pays professional fees on a fee-for-service basis directly to the hospital for inpatient psychiatric stays that are authorized by the Contractor. The facility fee portion will be paid by the Contractor. The professional fees are paid FFS and only the facility costs are included in the managed care capitation payment.

The process has been accompanied by the use of an Accountable Community of Health (ACH) group, the Southwest Regional Health Alliance, that was set up with funds from the CMS innovation grant funding.¹⁰⁵

The Southwest Regional Health Alliance has a 19-person Board of Directors that spans major hospital systems, medical groups, public officials and consumer advocates. It staffs a behavioral health advisory board that works on integration efforts such as reducing bottlenecks in sharing medical information and also participates in an "early warning system" in which integration performance measures are observed and commented on. This ACH concept encourages a substantive community involvement with the integration effort.

This southwest project also has a strong monitoring program which was initiated before the program began. There are performance measures and a 13-person Early Warning System Steering Committee. A draft report of the first 90-days of the integration is currently circulating for comment. The report discussed the implementation issues and what actions were taken to resolve them e.g. claims payment issues. The report also discusses performance measures such as changes in hospital emergency department use. However, the quantitative data only covers three months and is an insufficient data platform to discuss trends and the effect of seasonality, or the comparison against previous time periods.

Interviews with the managed care company staff indicate the companies meet frequently and have standardized their forms and referral and authorization procedures, so beneficiaries will not have multiple, different processes to navigate.

Case management staff of the managed care companies report that they have daily updates when a beneficiary is seen by a designated mental health professional for a 72-hour evaluation and Beacon provides daily reports on beneficiaries that contact crisis services. To the best knowledge of the managed care staff, these daily reports were not a process used by the previous BHO and are a useful first step in the early identification of who might need mental health services.

¹⁰⁵ The Accountable Health Communities Model is based on emerging evidence that addressing health-related social needs through improved clinical-community linkages can improve health outcomes and reduce costs and CMS has been encouraging their implementation.

Next Steps

As of this writing, the next group of counties to adopt full integration will be Chelan, Douglas and Grant counties in north-central Washington and Okanogan is likely to join them. HCA has employed the same deliberate implementation strategy of working with local leadership to obtain their backing, providing technical assistance and state staff aid and supporting an ACH. The Chelan-Douglas Health District. Implantation is expected in January 2018.

Although SSSB 6312-2014 mandated the creation of BHSs that managed both mental health and substance abuse services, it is not clear how integrated these services were when administered by the BHOs. According to BHO staff that PCG interviewed, state licensing regulations still have the effect of partitioning mental health and substance abuse into different delivery systems. This is a potential challenge and managed care plan staff will have to inform the state as to what extent state licensing practices interfere with effective integration activities.

5.6. Key Findings

States are increasingly limiting state hospital admissions to forensic patients and a smaller portion of civil patients, mainly those with psychotic disorders and bipolar diagnoses classified as high acuity due to behavioral or complex medical conditions.

Identifying the optimal number of beds per capita is challenged by: (1) a lack of consistent reporting and identification of available beds across public and private systems; and (2) issues quantifying population need as individuals face hurdles entering the system.

Facility treatment is moving toward recovery-oriented principles including the use of peer support programs and substance use treatment in state hospital settings. This trend reflects broader goals of person-centered care that permeate throughout physical and behavioral health guidelines.

Trend toward community-based treatment continues with significant focus on crisis interventions, integrated substance use disorder and identification and management of social and environmental issues that may significantly impact patient recovery.

System modernization and interoperability is key to both the effective transition of mental health patients through the system and integration with physical health. Mental health providers who have moved toward electronic health record adoption cite enhanced quality assurance, improved data reporting, improve productivity, reduced billing errors and the generation of client outcome measures among key advantages.

Funding mechanisms are evolving to further incentivize community care. Federal funding for institutional care continues to decline in favor of alternative, community-based models. The relationship between reduced disproportionate share funding and significant support for innovative models, such as delivery system reform incentive pools, exemplifies this trend.

6. Washington State Perspective

6.1. Stakeholder Input

To document the first-hand perspective of individuals directly involved in Washington's mental health system, PCG conducted a series of stakeholder interviews during August 2016. Stakeholders were identified by the state and consisted of the following representation:

- mental health providers and provider organizations
- Behavioral Health Organizations (BHOs)
- community hospitals
- advocacy organizations
- criminal justice system
- labor unions
- legislative staff
- State administrators
- State hospital staff
- Managed Care Organizations (MCOs) operating in the full integration early adopter region

The complete stakeholder interview schedule, interview guide and response log can be found in Appendices E, F and G, respectively. Appendix G provides a detailed log of issues, root causes and potential recommendations from different stakeholder groups. Based on this collection of input, major themes identified by stakeholders are summarized below.

Funding the System

The state has expressed interest in determining whether the BHOs financial structure should include provision of state hospital care, with the goal of improving hospital diversion and community resource utilization. If BHOs will assume risk for state hospital bed utilization, mental health providers and BHOs agree that the BHOs will need additional autonomy to de-authorize care for patients who no longer require state hospitalization. Further, including allocations for caseloads from the Developmental Disability Administration, US Department of Veterans Affairs and Home and Community Services/ Aging and Long Term Support Administration under this risk arrangement would require BHOs to assume risk for costs over which they have little control.

Stakeholders emphasized that placing BHOs at risk for hospitalizations represents only one tactic in a broader strategy to repair the system. With respect to BHOs and future models of managed care, providers emphasized that true integration of physical and behavioral health requires more than funding integration. They stressed that the state closely examine early adopter results before progressing in that area. Stakeholders also suggested that BHO and MCO contracts must align with the state's goals for the mental health system, appropriately incentivizing achievement of those goals across such contracts.

Several stakeholders posed provider reimbursement as another area for improvement, citing the need to: (1) increase rates for private facilities to care for low income patients; (2) differentiate case rates for outpatient services based on acuity; and (3) raise salaries for state hospital staff to attract qualified providers and reduce

turnover and vacancies. Broadly, stakeholders emphasized the need to direct current state hospital funding to support systemic changes.

Community Resources

Stakeholders overwhelmingly agreed that the system needs to increase and improve utilization of community resources, citing this issue as the main cause of admission and discharge bottlenecks at the state hospitals. Housing poses significant issues for patients on discharge, due to a lack of affordable housing options and effective connections to those options in many communities. Long term, inpatient and residential care options for individuals with complex issues, such as dementia, violent behaviors, sexual disorders and traumatic brain injury, represent another area for augmentation. Several stakeholders also expressed the need to augment effective community interventions, specifically noting peer support programs, substance use disorder treatment options, mobile crisis and crisis intervention team models for coordinated crisis response.

Standardization and Unification

To best serve patients across the state, the system must work toward a common set of goals under clear direction and leadership. Lack of standardization has created confusion and distrust among the system's various stakeholders. State hospital admission and discharge processes exemplify this issue as discussed below.

BHOs, providers and state hospital staff noted that they do not control which individuals are placed on the state hospital admission waitlist. Individuals who require treatment at the state hospitals are determined by Designated Mental Health Professionals assigned by the court system. However, physicians from both community and state hospitals expressed concern that the court's assessment does not align with their own clinical judgment in many cases.

Lack of standard admission criteria has led BHOs and providers to question whether state hospitals select lower acuity patients to admit to the hospital, leaving complex patients on the wait list. This perspective was emphasized in the western region of the state.

Both state hospitals also acknowledged that there is no standardized assessment for discharge readiness across wards or units in the hospital. Although each BHO employs a liaison to coordinate discharge with state hospital staff, lack of standardization has created ambiguity and contributed to discharge delays. Here again, ambiguity has created distrust in the community, as criminal justice representatives suspect that competency determinations favor difficult patients, sending them back into the correctional system.

Within the state hospitals, stakeholders noted that the reporting structure lacks unified leadership, contributing to differentiation in process and policy. At administrative level, legislative staff commented that many of the services needing improvement and further coordination exist under the same department. However, agencies often operate in silos, hindering execution of a clear and common direction.

Process Improvements

Lastly, several stakeholders suggested specific changes to state hospital operations, as documented below:

- Begin process to submit benefits applications well ahead of discharge to allow time for state processing.

- For Western State Hospital, improve communication among hospital staff, BHOs and community services to effectively manage patient placement at discharge.
- Limit the state hospital to serving the forensic population. Divert geriatric and adult civil patients to community-based facilities.
- Examine the process for placing forensic “flips” to limit impact on other waitlisted patients.
- Further expedite processing of forensic patients to move them into the appropriate treatment setting.

6.2. Staffing Model

In addition to the overall assessment of the Washington Mental Health System covered in this report and the recommendations report to follow, the state is required by Engrossed Substitute Senate Bill 6656 (ESSB 6656) and Second Engrossed Substitute House Bill 2376 (2ESHB 2376) to contract with an external consultant to examine the clinical role of staffing within the two adult state psychiatric hospitals. The consultants are tasked to collect, review and analyze data, collect and review stakeholder input, research and compare to national benchmarks, chart current structures and best practice research and provide final analysis and recommendations. The analysis must include an examination of:

- the clinical models of care
- current staffing models and recommended updates to the staffing model
- barriers to recruitment/retention of staff
- creating a sustainable culture of wellness and recovery
- increasing responsiveness to patients’ needs
- reducing Wards to an appropriate size
- the use of interdisciplinary health care teams
- appropriate staffing model and staffing mix to achieve optimal treatment outcomes considering patient acuity
- recommended practices to increase safety for staff and patients; and
- assist with implementation of recommended changes

In response to the statute, the DSHS has executed a contract with OTB Solutions (OTB) effective July 1, 2016. OTB Solutions is in the midst of their work on this contract and collaboration with the concurrent work of PCG should strengthen the quality of recommendations from both consultants. At the time of this report, OTB is compiling site visit findings and are in the process of data normalization to provide a baseline draft report. OTB has provided preliminary data to PCG, which with the addition of vacancy reports has allowed the reporting on staff positions by title provided in Section 4.7.

When OTB has completed its preliminary analysis, they will meet with the applicable State Hospitals Coordinated Quality Improvement Program (CQIP) committee to discuss. They will then provide a final recommendations report on the appropriate clinical staffing model for the state Hospitals as they are currently configured. The report will address the provision of safe, quality treatment, the achievement of optimal

treatment outcomes, the creation of a sustainable culture of wellness and recovery and achievement of increases responsiveness to patient needs.

The recommendations shall consider relevant regulations, patient acuity, facilities constraints, optimal use of professionals to the full scope of their licenses practice and incorporation into the model of provider classifications to enhance patient care and address workforce market shortages. OTB shall share insights on reducing barriers to recruitment and retention of staff and shall endeavor to recommend a model that is scalable, depending on patient acuity and ward size/hospital configurations. OTB's final report will be submitted to DSHS representatives and then presented to the Select Committee on Quality Improvement in the state Hospitals this fall.

6.3. Additional Efforts Underway

In addition to the clinical staffing model consultant efforts and the overall assessment offered in this report, there are several other concurrent behavioral health system improvement contracts at the state level. PCG is monitoring the progress and synchronization of these projects and collaborating efforts to strengthen the quality of recommendations that come from them.

Systems Improvement Agreement

The Systems Improvement Agreement (SIA) is a 13-month agreement effective June 2, 2016 between the Centers for Medicare and Medicaid Services (CMS), a division of the United States Department of Health and Human Services, Western State Hospital, Washington's DSHS and Washington's Department of Health (DOH). The SIA is being executed and implemented to improve patient treatment and overall safety after a complaint investigation and six revisit surveys lead CMS to determine that WSH has failed to implement and sustain systems to provide treatment interventions, ensure patient safety and implement quality controls. CMS issued a termination notice to Western State Hospital on March 1, 2016 that was effective April 1, 2016 but to provide additional time to complete the requirements, CMS extended Western State Hospital's termination date to June 3, 2016 and then proceeded to rescind the termination immediately after signing the SIA.

In addition to ensuring an effective system for identification, notification and action on safety and quality issues, DSHS also agreed to retain an independent expert consultant to assist in carrying out the actions described in the SIA. These duties include a gap analysis, root cause analysis and development of a list of recommendations - specifically in relation to quality, safety and compliance with Medicare Conditions of Participation (CoP) and Special CoPs for Psychiatric Hospitals.

DSHS has contracted with CMS-approved consultant, Clinical Services Management (CSM), to conduct a comprehensive healthcare quality improvement review. This review will consist of a functional assessment and analysis of Western State Hospital's systems. CSM shall:

- Submit a plan and methodology for the performance of an independent, comprehensive Hospital-wide analysis of current operations compared to industry accepted standards of practice.
- Assist Western State Hospital to improve the quality of patient care, meet applicable standards and make recommendations for hospital-wide changes and improvements.
- Submit a plan to the DSHS Assistant Secretary no later than 10 days following the execution of the contract. The plan shall include a schedule of performance of the analysis to include identification of necessary contractor and hospital resources and the time frames during which they will be required to be available.

- Identify gaps and recommendations to improving safety of staff and patients, patient care and to achieve compliance with all applicable standards.
- Conduct an analysis that includes a review of the following: quality and appropriateness of services, including direct patient care services; master treatment plans and active treatment services provided to patients in accordance with applicable standards; infection prevention practices; leadership/management accountability and supervision; qualified and supportive staffing resources; staff training and education; culture and teamwork; communication; and safety of patients and staff.

The SIA also required an initial report to CMS from independent consultants, which CSM submitted on August 8, 2016. CMS will review the report and notify CSM of any changes within fifteen days of receipt. If CMS accepts the report, they will notify DSHS and CSM of acceptance in addition to the due date for submission of a Corrective Action Plan. CSM will assist DSHS and Western State Hospital in the development and implementation of a Corrective Action Plan that addresses the recommendations made in the report. The Corrective Action Plan will identify the specific actions Western State Hospital will take, including the individuals responsible and milestones to achieve and sustain substantial compliance with all the Medicare CoPs. The timeline in the Corrective Action Plan must be approved by CMS and revisions may be requested prior to CMS accepting it. Once accepted, CSM will serve as oversight consultant and will provide feedback, oversight and monitoring of Western State Hospital's performance of the Corrective Action Plan and provide ongoing monthly reports to CMS related to Western State Hospital progress in implementation.

After Western State Hospital completes the Corrective Action Plan, if a Medicare certification survey demonstrates that WSH is substantially in compliance with all Medicare CoPs, CMS will send notice that Western State Hospital has achieved substantial compliance. If Medicare certification survey demonstrates that Western State Hospital has Condition-level non-compliance in one or more of the Medicare CoPs, CMS will reissue the termination that it rescinded pursuant to the SIA. If CMS reissues the termination, it will give Western State Hospital written notice consistent with requirements.

Workforce Development

On June 6, 2016 Governor Jay Inslee announced that the Workforce Training and Education Coordinating Board (herein referred to as the workforce board) in collaboration with the University of Washington Center for Health Workforce Studies, will evaluate current and projected workforce shortages in the behavioral health disciplines using Workforce Innovation and Opportunity Act discretionary funds.

The primary activities of this work will be to assess Washington's behavioral health workforce supply and demand to identify factors affecting access to behavioral health care in the state. The workforce board has held stakeholder meetings on July 26, 2016 in western Washington and September 1, 2016 in eastern Washington and have scheduled another stakeholder meeting on October 18, 2016.

Based on their findings, the workforce board will develop recommended action plan/strategies to address workforce-related factors that affect access to behavioral health care in the state, including the workforce needed to meet the goal of integrated primary care and behavioral health by 2020. Recommendations will consider workforce distribution, pipeline, education/training, recruitment and retention.

The workforce board will prepare a preliminary report and recommendations for the Governor's office and appropriate committees of the Legislature in late October 2016, with its final analysis and report due December 2017.

Jail Diversion Study

The Governor's office, through Executive Initiative, has contracted with an independent consultant, Joplin Consulting to identify methods of enhancing the safe and appropriate diversion of people with mental illness from Washington's criminal justice system.

The purpose of this project is to assess the current status of and expansion opportunities for diverting people with mental illness from Washington's criminal justice system. The assessment will include a review of existing diversion programs across the state as well as national best practices. Specific tasks include:

- Using a series of phone interviews and site visits, develop an inventory of programs in Washington state designed to divert people with mental illness from the criminal justice system.
- Using a series of phone interviews and a brief literature review, summarize national best practices on how to divert people with mental illness from the criminal justice system.
- Interview stakeholders and summarize findings on legal, financial or other barriers to diverting people with mental illness from Washington's criminal justice system.
- Explore and summarize other states' successful use of Medicaid funding to support diversion for people with mental illness from criminal justice systems.

Summary of findings on Washington jail diversion programs, nationally recognized jail diversion programs and from the national Medicaid policy scan will be reported September 30, 2016. Summary of findings from state-level information gathering will be reported October 31, 2016. Final report and recommendations on how to safely and appropriately divert individuals with mental illness from the criminal justice system and on funding jail diversion programs for individuals with mental illness by maximizing federal funding through the Affordable Care Act will be provided November 21, 2016.

Discharge Geropsychiatric Planning Initiative

The discharge Geropsychiatric planning initiatives comes from Engrossed Substitute Senate Bill 6656 (ESSB 6656) and requires DSHS Aging and Long-Term Support Administration (AL TSA) to reduce the demand for thirty beds (by the end of November 2016) currently being used by the Geropsychiatric population in state psychiatric hospitals by identifying and discharging patients from state psychiatric hospitals who are in need long-term care. The goal is to move patients suited to services in less restrictive settings to the community and redeploy resources to achieve patient and staff safety goals at the state psychiatric hospitals. AL TSA has been tracking discharge of Geropsychiatric patients from state psychiatric hospitals and with the use of Home and Community Services resources and are on track with the statute goal.

Discharge Planning Initiative

The discharge planning initiative also comes from ESSB 6656. This initiative requires DSHS to achieve a 14-day discharge standard, which would reduce the length of time between determination that a patient no longer requires active inpatient psychiatric treatment in the state hospital and can transition to a less restrictive setting in the community. Ahead of the effective date of July 2018, DSHS has started working toward improvements in this area and are in early stages of these efforts.

University of Washington Training Unit

In response to the Second Engrossed Substitute House Bill 2376 (2ESHB 2376) DSHS and Western State Hospital are in the process of executing a contract with the University of Washington to collaborate on a high quality forensic teaching unit that improves the quality of patient care and draws future psychiatrists to the State psychiatric hospitals. The tasks included in this agreement are to conduct an analysis and develop a plan, including an appraisal of risks, barriers and benefits to implementation of a forensic teaching unit. Details should be finalized early September 2016.

Select Committee on Quality Improvement in State Hospitals

The Select Committee on Quality Improvement in State Hospitals (SCQISH) was established in 2016 by ESSB 6656. The select committee composes eight voting members of the Legislature and one voting member appointed by the Governor. The committee also includes the heads of the Department of Social and Health Services and the Department of Labor and Industries, who are both nonvoting members. The committee is tasked with receiving updates, monitoring and making recommendations to the Governor, the Office of Financial Management and the Legislature on several topics including:

- State hospital structure, financing, staff composition and workforce development needs
- use of funds from the Governor's Behavioral Health Innovation Fund, also established in ESSB 6656
- monitoring progress on implementation of legislative policies
- reviewing survey findings concerning the safety of state hospitals

The select committee must convene at least quarterly through its expiration on July 1, 2019. Upcoming scheduled meetings are to be held on September 12, October 27 and November 17, 2016.

Trueblood

In late 2014, a lawsuit was filed against DSHS (case No C14-1178 MJP) claiming that the state was taking too long to get criminal defendants evaluated and into restoration treatment. After attempts by DSHS to negotiate a settlement were rejected, the case was finally heard in U.S. District Court. On April 2, 2015 a federal court ruled in the case, finding in favor of the plaintiffs and requiring that the state provide competency evaluations and restorations within seven days. The Court also ordered that a court monitor oversee the department's efforts to comply with the court's orders and provide monthly reports to the assigned monitor (which are available to the public), documenting the state's progress. A plan, documenting the state's long-term strategy to comply with the new seven-day standard is due to the Court by July 2, 2015. The state is to be in full compliance with the order by January 2, 2016.

DSHS has had success in reducing the time it takes to provide competency services for criminal defendants. They have added 96 new beds and hired 13 additional forensic evaluators. They have also created a new Office of Forensic Mental Health Services and established four outstation locations to conduct more timely competency evaluations. DSHS has started to pilot programs, one is a shared calendar system with King County to ensure evaluation services are scheduled in a timely manner and the other a diversion program to test innovative approaches using community supports to divert patients from the criminal justice system.

As a result of these successes, wait times for class members have improved from a high of 91.8 days to 12.5 days at Eastern State Hospital (ESH) and from 25.5 to 18.9 days at Western State Hospital (WSH). Wait times for inpatient restoration services dropped from a high of 90.8 days to 29 days at ESH and from 39 days to 29 days at WSH. And Wait times for in-jail evaluations went from 66.5 days to 13.8 days at ESH and from 20.7 to 9.6 days at WSH.

Enhanced Service Facilities Contract

The Washington State Legislature authorized AL TSA to develop Enhanced Services Facilities (ESFs) under Chapter 70.97 RCW based on an identified gap in community placement options for individuals with complicated personal care and behavioral challenges. This new category of licensed residential facility will provide a community placement option for individuals whose complicated personal care and behavioral challenges do not rise to a level that requires an institutional setting. Rather than extended and unnecessary stays in State Hospitals, patients who are no longer responding to active psychiatric treatment and who have been assessed as stable and ready for discharge can be referred to an ESF.

ESFs use high staffing ratios, behavioral and environmental interventions to serve individuals who are no longer receiving active treatment at a state psychiatric hospital. These facilities offer behavioral support, personal care services and nursing, a combination that is not generally provided in other licensed long-term care settings. Residents of ESFs access physical and behavioral health services through MCOs and BHOs. Actions to develop ESFs are as follows:

- development of the license, including rule-making and defining the licensing process
- development of the Enhanced Services Facilities contract which includes: (1) establishing Medicaid authority to fund placements; (2) developing provider qualifications and responsibilities; and (3) defining client eligibility
- procurement of quality providers
- budget appropriate to support 42 people statewide

Budget assumptions were revised to increase the daily rate paid to ESFs. As a result, the current budget will serve 28 ESF clients. Currently there are 20 ESF beds licensed; 8 in Spokane and 12 in Vancouver. There is additional development of ESF providers expected over the next year.

Behavioral Health Integration

During the 2014 legislative session, at Governor Inslee's request, the Legislature passed Engrossed Substitute Senate Bill 6312 (ESSB 6312) that integrates how the state purchases mental health and chemical dependency services for people with severe mental illness via managed care. This complements the innovative Medicaid purchasing measure, Engrossed Substitute House Bill 2572 (ESHB 2572) through mandating primary care services be available in mental health and chemical dependency treatment facilities and vice versa. It also creates financial incentives for local governments to "opt in" to full integration of behavioral health with physical health care. And it requires that our new behavioral health system provide access to recovery support services, such as housing, supported employment and connections to peers.

The legislation allows certified chemical dependency professionals and trainees who also hold a license that allows them to practice another affiliated health care profession to treat patients in settings such as doctors' offices and mental health treatment centers. The legislation also calls for the creation of a bipartisan task force

to make recommendations on how statewide integration of behavioral and physical health will take place. Those recommendations must move the state to full integration by 2020. The task force is also charged with recommending common service regions so state contracting for behavioral health (through DSHS) and physical health (through the Health Care Authority) can take place along the same time frames and in the same geographical areas.

The final legislation starts with the integration of mental health and chemical dependency services within BHOs which has taken effect as of April 1, 2016. Full integration of behavioral health and medical services will occur by 2020, with the southwest region of WA serving as the early innovator regions.

The Behavioral Health Integration Executive Oversight Committee has been established to help shape the strategies needed to achieve full integration, work with BHOs to ensure better integration of behavioral care in the primary care setting, work to include dually licensed chemical dependency professionals in their clinics and work within their local regions to pursue early innovator opportunities. The oversight committee is comprised of a group of staff and managers from the Behavioral Health Administration, Health Care Authority, Office of Financial Management and the Governor's office to develop assessments and action plans to accomplish this change.

For functional and financial integration, the agencies have been tasked to understand the functional, structural and financial changes needed to achieve financial and functional integration at the state level that best supports clinical integration. They reviewed the Early Adopter and BHO development process for lessons learned, identified the impacts on other agency and administration services that impact the full continuum of care and proposed a plan and timeline for functional, structural and financial alignment to achieve the changes needed to maximize success.

6.4. Key Findings

Community resources, both availability and accessibility, present significant challenges. Specific and significant shortfalls in affordable housing, substance use disorder services, peer support, crisis stabilization and appropriate residential facilities for individuals with complex needs represent the greatest concern. In areas where there are services available, accessing those services is hindered by awareness, the ability to make appropriate connections and willingness of private providers to accept high need, low income patients.

Ambiguity and lack of standardization are apparent throughout the current system. Processes for admission and discharge to the state hospitals are not well understood among those impacted by such determinations. Compounding this issue, admission, discharge and related evaluation protocols differ from facility to facility, creating confusion and distrust in the system.

Numerous process and operational challenges have been identified for the state hospital system. For both hospitals, continuity across wards and units, multiple staffing issues and a lack of recovery-oriented practices (such as peer support and substance use disorder services) were cited among these challenges. Many of these issues are exacerbated for Western State Hospital, where a significantly larger portion of this population is currently served.

It is not clear that increasing the financial risk of Behavioral Health Organizations, Developmental Disability or Aging and Long Term Support Administrations will resolve state hospital utilization issues in Washington. Data suggests utilization issues are localized and that most BHOs are not maximizing use of their bed allocations. The issues identified above, if not prioritized, will continue to hinder appropriate state hospital utilization under a per member per month risk structure and must be considered in any new model

of reimbursement. Stakeholders also stressed that placing BHOs at risk for state hospital beds will also require significant changes in the level of control that BHOs may exercise over the populations under the risk arrangement.

Jail diversion programs show promising results but require further study. As also discussed as an emerging best practice, results are preliminary and mixed in many states exploring this type of initiative. Findings from the jail diversion study currently underway will be key to addressing forensic overcrowding issues.

7. Major Findings Summary

State hospital utilization and operations face a number of challenges. High occupancy rates and a lack of alternative settings for complex patients are compounded by lean staffing models, organizational silos and a lack of recovery-oriented programming. The hospitals currently serve a broad mix of civil and forensic patients. However, best practices and current national trends suggest that state hospitals are moving toward a model that serves an increasingly limited patient demographic, mainly focused on the forensic population. Thus although capacity is strained, systemic issues are likely to continue if additional beds were added. Available utilization data from BHOs indicates significant variation in utilization of the state hospital system. However, lack of uniform allocation methodologies across regions and available acuity data confounds further analysis as to the appropriateness of such utilization.

Community based resources exist in a complex, disparate set of systems that does not effectively support complex patient needs. The challenges here are two-fold. First, there are insufficient community resources to support patients who, although having complex medical, social and behavioral needs, do not require state hospitalization. Second, services that are available may not be fully utilized as their availability is not reported or organized on a system-wide basis. Thus patients, providers and care managers alike struggle to identify available resources for patients in need. These issues are further compounded by a lack of interoperability and standardization in the systems that support these services.

Ambiguity and lack of system-wide standardization weakens the ability of providers, BHOs and patients alike to effectively use the system. Transition into and out of state hospital settings is managed through admission and discharge readiness assessments that vary significantly across the system and within facilities. Ambiguity regarding the reasons for admission and discharge has created skepticism among stakeholders regarding the appropriateness of patient care and ultimately contributes to delays in patient placement.

Best practices for mental health funding are incentivizing reduced institutionalization and increased outcomes-oriented community care. Reductions in federal funding for state hospitals concurrent with increased funding for delivery system reform and value-based purchasing exemplify this trend. However, effective transition toward this model requires significant focus on improving the availability and accessibility of community resources. Financial and non-financial strategies must be employed to accomplish this goal.

Appendix A

Data Sources Peer States

National Studies:

- Treatment Advocacy Center “Going, Going, Gone: Trends and Consequences of Eliminating State Psychiatric Beds” 2016. – Excluded from the TAC report are: Child and adolescent beds and residential and geriatric state hospital beds used for age-related conditions. The TAC report also found inconsistencies in reported bed data and when possible defaulted to data provided by the states.
- Substance Abuse and Mental Health Services Administration, “National Mental Health Services Survey (N-MHSS): 2012. Data on Mental Health Treatment Facilities.” BHSIS Series S-78, HHS Publication No. (SMA) 16-4949. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015. – Data is from 2012.
- 2015 National Outcome Measures (NOMS) from SAMHSA’s Uniform Reporting System – Data from 2015
- NRI data on State Mental Health Authority expenditures. Data from fiscal year 2013
- CMS Monthly Medicaid Enrollment Report – Total Medicaid and CHIP Enrollment, June 2016 (Preliminary)
- Mental Health America “Prevention and Early Intervention B4Stage4: The State of Mental Health in America 2016” – Data drawn for SAMHSA’s National Survey of Drug Use and Health (NSDUH) and the CDC’s Behavioral Risk Factor Surveillance System (BRFSS). Most of the data drawn from the 2016 report was from 2013 survey data.
- Additional data was received directly from Colorado, Illinois, Massachusetts, Minnesota and Oregon.

State Sources:

Colorado

- Interview with Dr. Patrick Fox, Chief Medical Officer at CO Department of Human Services
- Data compiled from state hospitals and sent by Kimberly Nordstrom, Division Director at CO Mental Health Institutes and Medical Director for the Office of Behavioral Health
- Colorado Department of Public Health and Environment – 2006-2016 Psychiatric bed counts
- Colorado Department of Human Services, Office of Behavioral Health “Needs Analysis: Current Status, Strategic Positioning, and Future Planning” April 2015
- Jennifer Brown, Greg Griffin (ed) “Breakdown: Mental Health in Colorado” Denver Post 2014, <http://extras.denverpost.com/mentalillness/>
- Colorado SIM Operational Plan, January 6, 2016
<https://drive.google.com/file/d/0BxUiTIOwSbPUY2xvRmNpX1JkMDg/view?pref=2&pli=1>

Illinois

- Interview with and data provided by Diana Knaebe, Director of IL Division of Mental Health
- Illinois Hospital Association, Illinois Hospitals Authorized Beds – 7/15/2016

- Illinois DHS fiscal year 2016 Budget Briefing. <http://www.dhs.state.il.us/page.aspx?item=75158>

Massachusetts

- PCG Analysis of the Bridgewater State Hospital, July 2016
- Department of Mental Health, Report on the Distribution of Funds, January 2016

Minnesota

- Data sent from the Division of Mental Health and Substance Abuse Treatment
- Bed data provided by MN Licensing Department and Minnesota Hospital Association
- DHS-6307: “Behavioral Health Homes Overview.” Minnesota Department of Human Services. July 2016.
- MN Hospital Bed Data fiscal year 2009 through fiscal year 2014, March 23, 2016

Oregon

- Oregon Health Authority, Behavioral Health Strategic Plan 2015 – 2018 <http://www.oregon.gov/oha/bhp/amhpac/PACDocs/OHA%208068%20Behavioral%20Health%20Strategic%20Plan-Final.pdf>
- OHA Addictions and Mental Health Oregon State Hospital 2015 – 2017 Governor’s Budget Presentation <https://www.oregon.gov/oha/Budget2015/OHA%20Oregon%20State%20Hospital%20Presentation.pdf>

Appendix B

Previous Reports on Discharge Barriers

Multiple reports on Washington behavioral health have discussed both forensic and civil admittances along with discharges from state hospitals and those policies that could reduce barriers to discharge. These reports are:

- The July 2004 Public Consulting Group (PCG) report titled “Mental Health Inpatient & Residential Bed Capacity;”
- The November 2004 PCG report titled “Capacity and Demand Study for Inpatient Psychiatric Hospital and Community Residential Beds Adults & Children;”
- The June 2007 Department of Social and Health Services (DSHS) report titled “Statewide Transformation Initiative Involuntary Treatment Act (ITA) Review Final Report;”
- The July 2007 University of Washington report titled “Washington Inpatient Utilization Management Project;”
- The March 2009 Geller report titled State Hospital Ward Sizes, “Discharge Practices, and Community Placement Issues;”
- The July 2011 Washington State Institute for Public Policy (WSIPP) report titled, “Inpatient Psychiatric Capacity in Washington State: Assessing Future Needs and Impacts (Part One);”
- The October 2011 WSIPP report titled, “Inpatient Psychiatric Capacity in Washington State: Assessing Future Needs and Impacts (Part Two);”
- The January 2013 WSIPP report titled “Standardizing Protocols for Treatment to Restore Competency to Stand Trial: Interventions and Clinically Appropriate Time Periods;”
- The September 2013 Rosen and Associates report titled, “Washington State Psychiatric Hospitals Workplace Violence Prevention Programs Review;”
- The June 2014 Gowensmith report titled “Forensic Mental Health Consultant Review Final Report;”
- The August 2014 Washington Supreme Court case, “Re: The Detention of D. W. et al;”
- The 2015 article by Joseph Bloom in the Journal of the American Academy of Psychiatry and the Law titled “Psychiatric Boarding in Washington State and the Inadequacy of Mental Health Resources;”¹⁰⁶

¹⁰⁶ See <http://www.jaapl.org/content/43/2/218.full.pdf+html>

- The January 2015 (DSHS) report titled “Quality Indicators and Outcomes for Persons Discharged from State Psychiatric Hospitals;”
- *The January 2015 WSIPP* report titled “Inpatient Psychiatric Capacity and Utilization in Washington State;”
- The April 2015 settlement of Trueblood et al v. Washington State DSHS;
- The June 2016 King county report titled “Community Alternatives to Boarding Task Force Final Report” and,
- The July 2016 Washington State Hospital Association report titled “Challenges with Discharging Patients to Post-Hospital Placement.”

Similarity of Findings

These reports are similar in identifying that the major cause of barriers to discharge is the lack of community resources. There are secondary factors that could be improved to expedite discharges such as a more efficient organization of how discharge planning is accomplished within the state hospitals and the restructuring of who is at financial risk for hospital bed use, but the major barrier is the availability and use of community resources for individuals with complex needs.

For example, the 162-page 2004 PCG report found:

- State spending for adult mental health residential and inpatient services remains significantly below peer state investment for comparable services.
- The lack of community-based residential and alternative community-based inpatient capacity is particularly apparent with specialty patient populations currently served by the state hospitals. It is estimated that up to 144 patients at Western State Hospital and an additional five patients at Eastern State Hospital could be better served in the community.
- During the past two years there has not been enough progress to create sufficient capacity to divert admissions from state hospitals or other psychiatric inpatient settings.
- There has not been adequate progress made in developing and locating sufficient community residential beds in most RSNs.
- The existing community psychiatric hospital bed capacity should be preserved, with opportunities to expand, to meet the increasing demand of the state’s population growth and decreasing reliance on state hospital beds. Preservation (and expansion) of the capacity requires a rate structure that fully reflects the cost of providing services to the consumers referred by the public system.

The June 2007 DSHS report titled Statewide Transformation Initiative Involuntary Treatment Act (ITA) Review Final Report found that:

- The actual statutory language of Washington’s involuntary treatment laws has less effect on the use of civil commitment than other factors, especially insufficient access to community mental health services and a lack of residential crisis alternatives.

The July 2007 University of Washington report although focused on utilization management within the state hospitals nonetheless mentioned barriers to discharge.

- Discharge barriers occur at all levels which prevent or slow discharge to the community, such as lack of placements for specialized populations, lack of structured residential placement and lack of housing and services for unfunded consumers.
- RSNs are not penalized for consumers that remain in state facilities unless they exceed their allotted bed census—this may act as a disincentive for RSNs to develop community services and
- Discharge barriers are not being tracked and reported in a systematic way.

The 2009 65-page Gellar report determined that:

- The length of stay at Washington’s state hospitals is high and there is significant variation between WSH and ESH.
- On any given day, there are approximately 150-170 people ready for discharge at Western State Hospital.
- In recent years, there have been many times where there was a “backup” of patients committed under 90/180-day court orders to the state hospitals who remained in community hospital beds due to a lack of bed capacity at the state hospitals.
- There are many indicators that support the findings that Washington’s current community-based bed capacity is insufficient to meet Washington state’s needs.
- RSN’s feel they have no influence on the length of stay in the state hospitals.
- Probably more patients than the clinically/medically/legally necessary ones are going from 72-hour to a 14-day commitment.
- In addition, almost assuredly, more patients than the clinically/medically/legally necessary ones are going from 14-day to 90-day commitment.
- RSN’s are paying more for State Hospital bed days than they would with a tighter system of oversight and active participation in discharge planning for inpatient treatment. This creates unnecessary tension between RSN’s and SH’s.
- System improvements needed are:

- Step-down capacity in all RSNs;
- Effective community-based utilization management of all residential beds;
- Fully functioning PACT teams, i.e., at capacity and effective;
- Targeted discharge and community tenure efforts for specifically identified populations;
- Community education to deal with stigma;
- Clarification and management of permanent placements and of transitioned placements; and
- Funding for development of target residential beds, i.e., for specific needs, rather than general residential beds.

The 150-page 2016 report “Community Alternatives to Boarding Task Force Final Report” mentions the word “discharge” 80 times and discusses at length the need for additional community resources.

- Specialized intensive resources in the community – that are critical to help people discharge from state and community hospitals – are severely limited, and as a result, many such programs have very long wait lists. Among these scarce resources are intensive mental health programs that often include housing and treatment services as an integrated package, as well as adult family homes administered by the state’s Home and Community Services unit.
- Significant gaps remain between available resources and the discharge needs of state and community hospital patients, especially those who fall into certain special populations.

Appendix C.1

State Hospitals Services Inventory

Western State Hospital Services Inventory

Direct Services
Adaptive Treatment Program (specialized treatment for patients with borderline intellectual functioning)
Behavioral Modification/Token economy systems
Care for Individuals with Dementia
Clinical Care Services
Cognitive Assessment
Cognitive Behavioral Therapy
Dental Services
Diagnostic Radiology
Dialectical Behavioral Therapy
Dietary
Forensic Risk Assessments
Habilitative Mental Health (DD Services)
Individual Psychotherapy
Inpatient Competency Evaluation and Restoration Treatment
Medical Services
Medication Management
Not Guilty by Reason of Insanity Treatment
Nursing Care
Occupational Therapy
Optometry
Pharmacy Services
Physical Therapy
Podiatry
Psychiatric Care
Psychological Assessment
Psychological Services
Recovery Groups/Treatment Malls
Recreational Therapy
Rehabilitation Screening and Services
Specialized treatment for individuals with traumatic brain injury
Substance Abuse Group Treatment
Suicide Risk Assessment and Treatment
Vocational Rehabilitation/Greenhouse
Direct Support Services
Adult Basic Education Classes/GED Preparation
Art Therapy
Assistance with Guardianship/Advance Directives
Beautician Services
Chaplain Services
Civil Commitment Evaluation and Testimony
Clinical Case Consultation
Discharge Planning: Community Outreach
Discharge Planning: Coordination with Behavioral Health Organizations
End of Sentence Review Hearings for Individuals with History of Sexual Offenses
Environmental/Custodial Services
Evening and Weekend Recreational Programming

Facilities and Environment of Care
Direct Support Services
Forensic Risk Review Board (reviews NGRI clients for discharge readiness and works with Public Safety Review Panel [PSRP])
Infection Control Services and Program
Jail Competency Evaluation Services
Lab Services (Limited, Reference lab for tests not completed onsite)
Motivational Interviewing Treatment
NGRI Forensic Community Program
Outpatient Case Management to NGRI Patients on Conditional Release
Patient Family Education/First Aid Mental Health Training
Patient Illness and Life Skills Education
Relapse Prevention Plan Assistance
Sanity and Diminished Capacity Evaluation and Testimony
Social Work Services

Eastern State Hospital Services Inventory

Direct Services
Active Treatment/Recovery Mall
Care/treatment of physical illness
Competency Evaluation (forensic)
Competency Restoration (forensic)
Dental Services
Diagnostic Radiology (portable radiology – no radiology department at ESH)
Laboratory Services
Medical Intervention
Medication Management/Education
Nutrition Services provided by registered dieticians
Occupational Therapy
Pharmacy
Physical Therapy
Psychiatric Services
Psychiatric Stabilization (civil – Adult and Geriatric Units; and Habilitative Mental Health {HMH} for patients with a developmental disability and a mental illness)
Psychology Services
Recreational Therapy
Speech Therapy
Direct Support Services
Accounting (onsite banking system for patients, Financial Benefits Coordinator, Part D Coordinator)
Discharge planning
Individual/Group/Family treatment and education
Medical Records
Pastoral
Referrals for CDP if necessary
Social Work
Treatment planning

Appendix C.2

Maple Lane and Yakima Services Inventory

Mental Health Treatment Services: State Competency Restoration Centers

Maple Lane (Centralia, WA, 30 beds) and Yakima (Yakima, WA, 24 beds)

The Maple Lane and Yakima residential facilities provide services required to house, in a secure setting, individuals referred for the Competency Restoration (CR) Services and to provide clinical behavioral health care services and related administrative and supportive services.

Competency Restoration Services include:

- Receipt of referrals
- Arranging for admissions
- Performance of initial and comprehensive assessments
- Development of individualized treatment plans
- Daily restorative treatment services including psychological, psychiatric and pharmaceutical care
- Milieu and behavior management and timely periodic reassessments

Services must include methods for addressing language and other barriers to effective care.

Appendix C.3

Services Required of Behavioral Health Organizations in State Contract

Core Mental Health Services. The Contractor shall provide the following services as described in Crisis Mental Health, Inpatient, Ancillary Costs and Residential Programs Sections and prioritize such services above any other services unless otherwise specified in this Agreement.

14.2.1. Crisis Mental Health Services: The Contractor must provide 24-hour, 7 day per week crisis mental health services to Individuals who are within the Contractor's Service Area and report they are experiencing a mental health crisis. There must be sufficient staff available, including Designated Mental Health Professionals, to respond to requests for crisis services. Crisis services must be provided regardless of the Individual's ability to pay. Crisis mental health services may include each of the following:

14.2.1.1. Crisis Services: Evaluation and treatment of mental health crisis to all Individuals experiencing a crisis. A mental health crisis is defined as a turning point in the course of anything decisive or critical, a time, a stage or an event or a time of great danger or trouble, the outcome of which decides whether possible bad consequences will follow. Crisis services must be available on a twenty four (24) hour basis. Crisis Services are intended to stabilize the person in crisis, prevent further deterioration and provide immediate treatment and intervention in a location best suited to meet the needs of the Individual and in the least restrictive environment available. Crisis services may be provided prior to completion of an intake evaluation. Services must be provided by or under the supervision of a Mental Health Professional.

14.2.1.2. Stabilization Services: Services provided to Individuals who are experiencing a mental health crisis. These services are to be provided in the person's own home or another home-like setting or a setting which provides safety for the Individual and the Mental Health Professional. Stabilization services shall include short-term (less than two (2) weeks per episode) face-to-face assistance with life skills training and with the understanding of medication effects and side effects. This service includes: a) follow up to crisis services; and b) other Individuals determined by a Mental Health Professional to need additional stabilization services. Stabilization services may be provided prior to an intake evaluation for mental health services. This service may include cost for room and board.

14.2.1.3. Involuntary Treatment Act Services: Mental Health - Includes all services and administrative functions required for the evaluation for involuntary detention or involuntary treatment of Individuals in accordance with RCW 71.05, RCW 71.24.300 and RCW 71.34. This includes all clinical services, costs related to court processes and transportation. Crisis Services become Involuntary Treatment Act Services when a Designated Mental Health Professional (DMHP) determines an Individual must be evaluated for involuntary treatment. The decision making authority of the DMHP must be independent of the BHO administration. ITA services continue until the end of the involuntary commitment.

14.2.1.4. Freestanding Evaluation and Treatment Services: Services provided in freestanding inpatient residential (non-hospital/non-IMD) facilities licensed by the Washington State Department of Health and certified by DSHS to provide Medically Necessary evaluation and treatment to the Individual who would otherwise meet hospital admission criteria. At a minimum, services include evaluation, stabilization and treatment provided by or under the direction of licensed psychiatrists, nurses and other Mental Health Professionals and discharge planning involving the Individual, family, significant others so as to ensure

continuity of mental health care. Nursing care includes but is not limited to performing routine blood draws, monitoring vital signs, providing injections, administering medications, observing behaviors and presentation of symptoms of mental illness. Treatment modalities may include Individual and family therapy, milieu therapy, psycho-educational groups and pharmacology. The Individual is discharged as soon as a less-restrictive plan for treatment can be safely implemented. This service is provided for individuals who pose an actual or imminent danger to self, others or property due to a mental illness or who have experienced a marked decline in their ability to care for self, due to the onset or exacerbation of a psychiatric disorder. The severity of symptoms, intensity of treatment needs or lack of necessary supports for the individual does not allow him/her to be managed at a lesser level of care. This service does not include cost for room and board. DSHS must authorize exceptions for involuntary length of stay beyond a fourteen (14) calendar day commitment.

14.2.2. Crisis mental health services may be provided without an intake evaluation or screening process. The Contractor must provide:

14.2.2.1. Emergent Care within two (2) hours of the request received from any source for crisis mental health services.

14.2.2.2. Urgent care within twenty four (24) hours of the request received from any source for crisis mental health services.

14.2.3. The Contractor must provide access to all components of the Involuntary Treatment Act to persons who have mental disorders in accordance with state law (RCW 71.05 and RCW 71.34) and without regard to ability to pay.

14.2.4. The Contractor must incorporate the statewide Designated Mental Health Professionals (DMHP) Protocols listed on the DBHR intranet or its successor into the practice of Designated Mental Health Professionals.

14.2.5. The Contractor must have policies and procedures for crisis and mental health ITA services that implement the following requirements:

14.2.5.1. No DMHP or crisis intervention worker shall be required to respond to a private home or other private location to stabilize or treat a person in crisis, or to evaluate a person for potential detention under the state's involuntary treatment act, unless a second trained individual accompanies them.

14.2.5.2. The clinical team supervisor, on-call supervisor or the individual professional acting alone based on a risk assessment for potential violence, shall determine the need for a second individual to accompany them.

14.2.5.3. The second individual may be a law enforcement officer, a Mental Health Professional, a mental health paraprofessional who has received training required in RCW 49.19.030, or other first responder, such as fire or ambulance personnel.

14.2.5.4. No retaliation may be taken against an individual who, following consultation with the clinical team or supervisor, refuses to go to a private home or other private location alone.

14.2.5.5. The Contractor must have a plan to provide training, mental health staff back-up, information sharing and communication for crisis outreach staff who respond to private homes or other private locations.

14.2.5.6. Every Mental Health Professional dispatched on a crisis visit, shall have prompt access to information about any history of dangerousness or potential dangerousness on the client they are being sent to evaluate

that is documented in crisis plans or commitment records and is available without unduly delaying a crisis response.

14.2.5.7. Every Mental Health Professional who engages in home visits to Individuals or potential Individuals for the provision of crisis services shall be provided by the Contractor or Subcontractor with a wireless telephone or comparable device for the purpose of emergency communication.

14.2.6. Psychiatric Inpatient Services: Community Hospitals and Evaluation and Treatment Facilities: The Contractor shall:

14.2.6.1. Develop, maintain or purchase Involuntary Treatment Act (ITA) certified treatment beds to meet the statutory requirements of RCW 71.24.300(6)(c).

14.2.6.2. Provide or purchase psychiatric inpatient services for the following:

14.2.6.2.1. Individuals who agree to be admitted voluntarily when it is determined to be Medically Necessary.

14.2.6.2.2. Individuals who are involuntarily detained in accordance with RCW 71.05 or RCW 71.34, and who are either eligible under MCS or who are not eligible for any other medical assistance program that would cover this hospitalization.

14.2.6.2.3. Individuals at least twenty two (22) years of age and under sixty five (65) years of age who are Medicaid-Individuals and are admitted to a residential facility that is classified as an Institution for Mental Diseases (IMD) defined in 42 CFR 435.1010.

14.2.6.3. Implementation of Court Decision Detention of D.W., et al. The BHO shall make use of Detention of D.W., et al funding for only the following expenses:

14.2.6.3.1. Use of IMD beds opened after August 7, 2014, for services provided to non-Medicaid clients when the admission of a non-Medicaid client results in bed days above the average utilization of bed days:

14.2.6.3.1.1. The average utilization of bed days will be calculated from a standard report (WA State DBHR Mental Health Service Reports – Community Hospital and E&Ts Client Counts by BHO) generated by DBHR's System for Communicating Outcomes, Performance and Evaluation (SCOPE) and covering the time period of 7/1/2013 – 6/30/2014.

14.2.6.3.1.2. The monthly number of bed days that exceed the average utilization of bed days (“incremental increase”) shall be determined by subtracting the average utilization of bed days from the BHO's calculation of the actual number of bed days utilized in that month. DBHR will provide this baseline data.

14.2.6.3.2. The BHO may bill DSHS monthly for any non-Medicaid bed days or non-Medicaid expenses in approved facilities at current rates for the incremental increase experienced by the BHO during that month. Bills may only be submitted for bed usage in the facilities listed in Exhibit I, Additional Bed Capacity, Table 1.

14.2.6.3.3. Expenses incurred after September 18, 2014, for the provision of mental health services as described in the emergency WAC below for individuals hospitalized with a single bed certification in a community hospital, when the hospital does not provide these services directly.

“The facility that is the site of the proposed single bed certification confirms that it is willing and able to provide directly, or by direct arrangement with other public or private agencies, timely and appropriate mental health treatment to the Individual suffering from a mental disorder for whom the single bed certification is sought”.

14.2.6.3.4. The BHO must provide back-up documentation of costs such as a contract or Memorandum of Understanding (MOU) with the hospital to the DSHS Contact listed on page 1 prior to payment being approved by the Department.

14.2.6.3.5. Operating funds are provided to North Sound BHO and Pierce/Optum BHO for those E & T facilities listed in Exhibit I, Table 2, as part of the expansion of E & T capacity resulting from the Court Decision Detention of D.W., et al. E & T services may be accessed by all BHOs based on the admission policies and procedures of the operating BHO.

14.2.7. Community Hospital Certification Process: The Contractor shall adhere to the requirements set forth in the Community Psychiatric Inpatient Process as provided by DBHR.

14.2.7.1. The Contractor shall have a Care Manager available twenty four (24) hours per day to respond to requests for inpatient certification. Certification decisions for psychiatric inpatient care must be made within twelve (12) hours of the initial call.

14.2.7.2. A Notice of Determination must be provided if certification is denied for the admission.

14.2.8. Psychiatric Inpatient Services: State Hospitals:

14.2.8.1. The Contractor shall reimburse DSHS for State Hospital days of care that exceed the daily allocation of State Hospital beds. The Contractor’s daily allocation of State Hospital beds is provided in Exhibit D.

14.2.8.1.1. If the Contractor disagrees with the BHO/patient assignment, it must request a reassignment within thirty (30) calendar days of admission. If a request to change the assignment is made within thirty (30) calendar days of admission and the request is granted, the reassignment will be retroactive to the date of admission.

14.2.8.1.2. If a request comes in after the 30th calendar day of admission and is granted, the effective date of the reassignment will be based on the date DSHS receives the reassignment request form. All reassignment requests are to be made using the Hospital Correction Request Form. The form is attached to the State Hospital/BHO Working Agreement. This process shall be described in the working Agreement between the Contractor and the State Hospital.

14.2.8.2. Ensure Individuals are medically cleared, if possible, prior to admission to a State Psychiatric Hospital.

14.2.8.3. Respond to State Hospital census alerts by using best efforts to divert admissions and expedite discharges by utilizing alternative community resources and mental health services.

14.2.8.4. The Contractor or its designee shall monitor individuals discharged from inpatient hospitalizations on Less Restrictive Alternatives (LRA) under RCW 71.05.320.

14.2.8.5. The Contractor or its designee shall offer mental health services to assist with compliance with LRA requirements.

14.2.8.6. The Contractor or its designee shall respond to requests for participation, implementation and monitoring of Individuals receiving services on Conditional Releases (CR) consistent with RCW 71.05.340. The Contractor or designee shall provide mental health services to assist with compliance with CR requirements.

14.2.8.7. The Contractor or designee shall ensure provision of mental health services to Individuals on a Conditional Release under RCW 10.77.150.

14.2.8.8. For conditional releases under RCW 10.77, Individuals in transitional status in Pierce or Spokane County will transfer back to the responsible BHO upon completion of transitional care. Individuals discharged to an BHO other than the responsible BHO will be done so according to the Inter-BHO agreement described in the State Hospital Working Agreement.

14.2.8.9. Maintain or develop a written working agreement with the State Hospital in its Service Area within 90 calendar days of the effective date of this Agreement. The Agreements must include:

14.2.8.9.1. Specific roles and responsibilities of the parties related to transitions between the community and the hospital.

14.2.8.9.2. A process for the completion and processing of the Inter-BHO Transfer Request Form for Individuals requesting placement outside of the BHO of residence.

14.2.8.9.3. Collaborative discharge planning and coordination with cross-system partners.

14.2.8.9.4. Identification and resolution of barriers which prevent discharge and systemic issues that create delays or prevent placements in the Contractor's Service Area.

14.2.8.10. The Contractor shall coordinate with the Department of Social and Health Services- Home and Community Services (HCS) regional office to support the placement of persons discharged or diverted from State Hospitals into HCS placements. In order to accomplish this, the Contractor will:

14.2.8.10.1. Whenever possible, prior to referring a person with a diagnosis of dementia for a ninety (90) calendar day commitment to a State Psychiatric Hospital:

14.2.8.10.2. Ensure that a request for a CARE assessment is made as soon as possible after admission to a hospital psychiatric unit or Evaluation and Treatment facility in order to initiate placement activities for all persons who might be eligible for long-term care services. HCS has agreed to prioritize requests for CARE assessments for Individuals who have been detained to an E&T or in another setting.

14.2.8.10.3. Request and coordinate with HCS, a scheduled CARE assessment for such persons. If the assessment indicates functional and financial eligibility for long-term care services, coordinate efforts with HCS to attempt a community placement prior to referral to the State Hospital.

14.2.8.10.4. For Individuals (both those being discharged and those being diverted) whose CARE assessments indicate likely functional and financial eligibility for long-term care services:

For Individuals (both those being discharged and those being diverted) whose CARE assessments indicate likely functional and financial eligibility for long-term care services:

14.2.8.10.4.1. The Contractor will coordinate with HCS placement activities with one entity designated as being responsible for those activities. This designation will be documented in writing and agreed upon by both the Contractor and HCS. Where such designation is not made the responsibility shall be the Contractor's.

14.2.8.10.4.2. The responsible entity will establish and coordinate a placement or discharge planning team that includes Contractor staff, HCS assessors and other community partners, as necessary, to develop a plan of action for finding a safe, sustainable placement.

14.2.8.10.4.3. The Contractor will ensure coordination and communication will occur between those participants involved in placement activities as identified by the discharge planning team.

14.2.8.10.5. If a placement has not been found for an Individual referred for long-term care services within thirty (30) calendar days, the designated entity will convene a meeting to review the plan and to make adjustments as necessary. Such review meetings will occur at least every thirty (30) calendar days until a placement is affected.

14.2.8.10.6. When Individuals being discharged or diverted from State Hospitals are placed in a long-term care setting, the Contractor will:

14.2.8.10.6.1. Coordinate with HCS and any residential provider to develop a crisis plan to support the placement. The model crisis plan format is available on the DBHR website.

14.2.8.10.6.2. When the Individual meets access to care criteria, coordinate with HCS and any residential provider in the development of a treatment plan that supports the viability of the HCS placement.

14.2.9. Children's Long-Term Inpatient Programs (CLIP):

14.2.9.1. The Contractor shall coordinate with the Children's Long-term Inpatient Programs ("CLIP") Administration to develop CLIP resource management guidelines and admissions procedures. The Contractor shall enter into, and comply with, a written agreement with the CLIP Administration regarding resource management guidelines and admissions procedures.

The Contractor shall integrate all regional assessment and CLIP referral activities, including the following:

14.2.9.1.1. Create and maintain a local process to assess the needs of children being considered for voluntary admission and coordinate referrals to the CLIP Administration.

14.2.9.1.2. When a person under age eighteen (18) is committed for 180 calendar days under RCW 71.34, the Contractor must assess the child's needs prior to the admission to the CLIP facility. The Contractor must provide a designee who participates in the CLIP Placement Team assignment of children subject to court-ordered involuntary treatment. A BHO representative will share the community and/or family recommendations for CLIP program assignment of committed adolescents.

14.2.9.1.3. Assess the needs of juveniles transferred for evaluation purposes by the Juvenile Rehabilitation Administration (JRA), or under RCW 10.77 to the Child Study and Treatment Center (CSTC).

14.2.9.1.4. Ensure that all required CLIP application materials, including community/family CLIP placement recommendations are submitted to the CLIP Administration prior to consideration of voluntary referrals.

14.2.9.1.5. The BHO shall provide the legal guardian and youth aged thirteen (13) and over with a written copy of the CLIP Administration Appeal Process when the BHO denies a voluntary application for CLIP services.

14.2.9.2. After CLIP Admission, the Contractor must provide Rehabilitation Case Management, which includes a range of activities by the Contractor's or BHA's liaison conducted in or with a facility for the direct benefit of the admitted youth. This person is the primary case contact for CLIP programs responsible for managing Individual cases from pre-admission through discharge. The Contractor's liaison or designated BHA must participate in treatment and discharge planning with the CLIP treatment team.

14.2.9.3. Review for prior authorization recommendations for short-term/acute hospitalization when it is determined by the CLIP program that this is required.

14.2.10. Inpatient Coordination of Care:

14.2.10.1. The Contractor shall ensure that contact with the inpatient staff occurs within three (3) business days of an authorized voluntary or involuntary admission. The Contractor's liaison or BHA must participate throughout the admission in treatment and discharge planning with the hospital staff.

14.2.10.2. The Contractor or its designee shall provide to the inpatient unit any available information regarding the Individual's treatment history at the time of admission. The Contractor or its designee must provide all available information related to payment resources and coverage.

14.2.10.3. The Contractor's liaison or designated BHA must participate in treatment and discharge planning with the inpatient treatment team.

14.2.10.4. The Contractor's liaison or designated BHA must participate throughout the inpatient admission to assist with appropriate and timely discharge for all Individuals regardless of diagnosis.

14.2.10.5. The assigned BHA must offer, at minimum, one follow-up service within seven (7) calendar days from discharge to an Individual who has been authorized for an inpatient admission or involuntarily committed.

14.2.11. Ancillary Costs: With the funds provided under this Agreement the Contractor is also expected to prioritize payments for expenditures associated with providing Medically Necessary crisis and residential services for Medicaid Enrollees that are not included in the Medicaid State Plan or the 1915(b) Waiver. Costs include, but are not limited to, room and board in hospital diversion settings or in a residential or freestanding Evaluation and Treatment facilities and Administrative Costs related to the Involuntary Treatment Act.

14.2.12. Residential Mental Health Programs: Residential settings and programs shall be available and provided based on the Individual's needs and within Available Resources per the Contractor's policies and procedures. The Contractor must maintain Level of Care Guidelines that detail when a client may receive Residential services. This plan may include memorandums of understanding or contracts to purchase or provide a residential program outside of the Contractor's Service Area when an Individual requires a level of residential support which is not available within the Contractor's Service Area. Residential programs and settings may include the following:

14.2.12.1. Long-term intensive adaptive and rehabilitative psychiatric care such as is provided in Adult Residential Rehabilitation Centers.

14.2.12.2. Supervised living such as residential programs developed to serve Individuals diagnosed with a major mental illness in nursing homes, boarding homes or adult family homes.

14.2.12.3. Supported housing services such as intensive services provided to maintain Individuals in unlicensed individual or group home settings including transitional or permanent housing.

14.2.13. The Contractor shall maintain the ability to provide Individuals with an intake evaluation at his or her residence, including adult family homes, assisted living facilities or skilled nursing facilities, including to persons discharged from a State Hospital or evaluation and treatment facilities to such placements when the Individual requires an on-site service due to medical needs.

14.2.14. The Contractor shall maintain the ability to provide services to Individuals in their residence, including adult family homes, assisted living facilities and skilled nursing facilities.

Appendix C.4

Washington State Treatment Services Available through Behavioral Health Organizations (BHOs)

Extracted from Washington State Behavioral Health Benefits Booklet published by the Department of Social and Health Services, Division of Behavioral Health and Recovery

Intake Evaluation - Identifies your needs and goals and helps you and your mental health care provider to decide a treatment plan.

Crisis Services – 24 hour services to help stabilize you in a location that is best suited to meet your needs. You do not need an intake evaluation before this service.

Individual Treatment Services - Counseling and/or other activities designed to meet your service plan goals.

Medication Monitoring - Services to check how your medication is working and to help you take it correctly.

Group Treatment Services – Counseling with others who have similar challenges

Peer Support – Help and support with navigating the public mental health system and reaching your recovery goals, provided by a trained person who is in recovery from mental illness

Brief Intervention and Treatment - Short term counseling focused on a specific problem

Family Treatment - Family centered counseling to help build stronger relationships and solve problems

High Intensity Treatment - Services provided by a team of mental health providers to help you meet your goals in your individual plan

Therapeutic Psychoeducation - Education about mental health conditions, treatment choices, medications and recovery, including supports and/or supportive services

Day Support - Intensive program to learn or assist with independent living skills

Evaluation and Treatment/Community Hospitalization – Medically necessary inpatient crisis care. You do not need an intake evaluation before this service

Stabilization Services - Provided in your home or home-like setting to help prevent a hospital stay. You do not need an intake evaluation before this service

Rehabilitation Case Management - Coordination between your inpatient and outpatient mental health services. This might be part of your intake evaluation

Residential Services - Services provided where you live if you live in a group setting

Evaluations for Special Populations – Treatment planning assistance from a specialist who works with children, older adults and people from multi-cultural backgrounds

Psychological Assessment – Testing that helps with diagnosis, evaluation and treatment planning

Appendix C.5

Assisted Living Facility Service Packages

Assisted Living Facilities that provide care for state-funded (Medicaid) residents offer one or more of the following service packages, as described on the DSHS website. These are services specifically developed as alternatives to skilled nursing facilities. While individuals with mental health diagnoses that also have a need for assistance with activities of daily living do receive services in these settings, it is a very small percentage.

Adult Residential Care (ARC)

This service package includes helping a resident who is able to take his/her own medication but needs some help (e.g. a reminder to take it or the medication handed to him/her) and personal care (e.g. bathing, dressing, personal hygiene). Residents who need to be monitored for their safety may get limited supervision.

Enhanced Adult Residential Care (EARC)

This service package includes all of the services as listed in the Adult Residential Care (ARC) package above and help for a resident who can't take his/her own medication (medication administration). Some type of nursing care must be provided occasionally. No more than two people will share a room. This service package includes all of the services as listed in the Adult Residential Care (ARC) package above and help for a resident who can't take his/her own medication (medication administration). Some type of nursing care must be provided occasionally. No more than two people will share a room.

Enhanced Adult Residential Care - Specialized Dementia Care Services

This service package includes all services as outlined in the Enhanced Adult Residential Care package above and additional services for a resident with dementia.

Assisted Living

This service package includes a private apartment. Some type of nursing care must be provided occasionally and help is available for medication administration and personal care.

Appendix C.6

Matrix of Services for Residential Support of Clients with Challenges to Community Placement

Contract	Status	Contract elements	Stipulations
Adult Family Home (AFH), Enhanced Adult Residential Care (EARC), Adult Residential Care (ARC) or Assisted Living (AL) with Community Option Program Entry System (COPEs)/Medicaid Personal Care (MPC) Services	<ul style="list-style-type: none"> Current 	<ul style="list-style-type: none"> MPC and/or Community First Choice (CFC) level of Personal Care 	<ul style="list-style-type: none"> Client must be functionally/financially eligible
Roads to Community Living (RCL) Program And/or WA Roads Services Demonstration Services	<ul style="list-style-type: none"> Current 	<ul style="list-style-type: none"> For those on Roads to Community Living (RCL), personal Care coded to RCL Demonstration services available through specific contracts WA Roads provides RCL-like services promote community stability for people who don't qualify for RCL Services include: CCGs, behavior support, client training, professional supports (includes MH/CD) 	<ul style="list-style-type: none"> Must be RCL eligible client into an RCL eligible setting to use RCL services WA Roads uses State only dollars
Expanded Community Services Available in: <ul style="list-style-type: none"> ECS-Contracted Adult Family Home or ECS-Contracted Assisted Living Facility (also available in SNF) 	<ul style="list-style-type: none"> Current AFH, EARC and SNF contracts exist in each region (resource developers work with Regions to expand as needed) More than 650 people currently served in residential settings and additional in SNF 	<ul style="list-style-type: none"> COPEs level personal care AND behavior support from ECS Contracted Behavior Support team ECS contracted AFH provider must coordinate care with the ECS contracted Behavior Support Team 	<ul style="list-style-type: none"> Client must be functionally/financially eligible Automatic eligibility for people leaving state hospitals AND must receive Regional Authorization, using the ECS Authorization Form (scoring tool) Not all clients in the facility receive the ECS rate and support Add on rate that covers care coordination with behavior support team and additional services provided in home for clients who meet ECS eligibility

Contract	Status	Contract elements	Stipulations
<ul style="list-style-type: none"> • Beds available in all regions, gaps in rural/outlying areas • Continuous expansion of resource statewide 			<ul style="list-style-type: none"> • COPES CARE rate + ECS Add-on SSPS code = ECS Rate • Current ECS Rate=\$117
<p>Specialized Dementia Program</p> <p>EARC-SDC</p> <p>Available in:</p> <p>SDC contracted ALFs</p>	<ul style="list-style-type: none"> • Current 	<ul style="list-style-type: none"> • COPES level personal care AND (eligibility being revised) • Total Rate for SDC package of services with specific SSPS code 	<ul style="list-style-type: none"> • Must have an irreversible diagnosis of Dementia and also meet the SDC Eligibility • Provider expected to provide behavior support within rate
<p>Residential Support Waiver</p> <p>Specialized Behavior Support</p> <p>Will be available in:</p> <p>SBS-contracted AFHs</p> <p>ESFs (see below)</p>	<ul style="list-style-type: none"> • Current for SBS-AFH 	<ul style="list-style-type: none"> • Specific care planning requirements, to cover elements such as Activities, Behavior, Crisis Prevention and Intervention • Coordination with a separately contracted Behavior Support Contractor (generally the ECS contracted behavior support providers) • Staffing to include: additional 6-8 hours of staffing above the staffing already provided in AFH for each SBS resident • 10 of the 12 Continuing Ed hours required of caregivers must be specific to the population served by SBS contract • Not to exceed 3 SBS residents in any home 	<ul style="list-style-type: none"> • Client must be functionally/financially eligible • AND must receive Authorization by HQs, using the Residential Support Waiver request tracking tool (in beta-testing, based on Waiver eligibility) • Per CBA, may be tied to state hospital discharges OR local psychiatric beds • Current Rate, based on staffing requirements: base rate plus bargained SBS add-on rate • Rate: CARE rate + \$104.33 SBS add-on

Contract	Status	Contract elements	Stipulations
<p>Enhanced Service Facilities New license category</p>	<ul style="list-style-type: none"> • Current, one 	<ul style="list-style-type: none"> • Service package in development, must meet requirements of both RCW 70.97 and Budget • Will offer services/supports above and beyond what is available through any of the contracts listed above • Draft Contract includes: <ul style="list-style-type: none"> ○ 4:1 staffing ration ○ MH professional on board 8 hrs ○ RN or LPN on board 24 (RN required 20 hrs week) ○ Extra training requirements ○ Very specific crisis prevention planning and care planning that includes pieces we don't call out in other settings ○ behavior/MH embedded in rate, specific professional FTE on staff or contracted by Contractor • Budget does not include ability to provide ITA services (i.e. detention or forced meds) 	<ul style="list-style-type: none"> • Specific client eligibility and authorization per client • Per Budget, must be discharging from a state hospital and have behavioral support needs above and beyond what current facilities can address • Current Rate, per cost neutrality in Waiver and based on staffing requirements: \$350-425/day)

Appendix C.7

Matrix of Services for Residential Support of Clients with Challenges to Community Placement

The service inventory reflects data from the fiscal year 2015 Medicaid and non-Medicaid revenue and expenditures reports from RSNs. The geographic regions are divided by RSN regions from 2015 to accurately reflect the data from this time, therefore the regions do not completely align with the current BHO regions. Additionally, the 18 State Plan required benefits and data on residential support facilities are also included in the data inventory.

There are limitations to using reported RSN services from expenditure reports as there known inconsistencies with data reporting across RSNs. Furthermore, the inventory should not be read as a comprehensive list of behavioral health services available in the state. RSN/BHOs may have specialized diversion programs or supportive services that are not captured in the Medicaid and non-Medicaid revenue and expenditure reports. In King County, there several other programs and services listed in the “Community Alternatives to Boarding Task Force Final Report” that are not listed in the Medicaid and non-Medicaid revenue and expenditure reports. These services are not included in the inventory as this level of detail for services was not available for all BHOs, therefore their inclusion would cause an inaccurate comparison of services across geographic regions.

Please note that this inventory below excludes services from Eastern and Western State Hospital.

Service	Chelan-Douglas	Grays Harbor	Greater Columbia	King	North Sound	Peninsula	Pierce	Southwest WA BH	Spokane	Thurston Mason	Timberlands
BHO Outpatient Services											
Crisis Services	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Evaluation & Treatment		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mental Health Residential Treatment			✓	✓	✓	✓	✓	✓		✓	✓
Intake Evaluation	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Individual Treatment Services	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Group Treatment Services	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Service	Chelan-Douglas	Grays Harbor	Greater Columbia	King	North Sound	Peninsula	Pierce	Southwest WA BH	Spokane	Thurston Mason	Timberlands
Brief Intervention and Treatment	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Family Treatment	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
High Intensity Treatment	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Stabilization Services	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Psychological Assessment	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Roads to Community Living					✓				✓	✓	
BHO Direct Services											
Medication Management	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medication Management	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Peer Support	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Therapeutic Psychoeducation	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Day Support	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Residential Services	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Evaluations for Special Populations	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Inpatient Treatment	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓
ITA Commitment Services			✓	✓	✓	✓		✓		✓	

Service	Chelan-Douglas	Grays Harbor	Greater Columbia	King	North Sound	Peninsula	Pierce	Southwest WA BH	Spokane	Thurston Mason	Timberlands
ITA Judicial/ITA Administrative	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓
ITA 180-day Commitment Hearings					✓		✓				
Medicaid Personal Care	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
Triage Nursing Services					✓					✓	
Congregate Care Facilities (CCFs)							✓				
Housing Authority Program				✓							
Next Day Appointment Program				✓							
Mobile Crisis Team				✓							
Jail Services	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Expanded Community Services (ECS)				✓	✓	✓	✓	✓		✓	✓
Program for Active Community Treatment (PACT)	✓		✓	✓	✓	✓	✓	✓	✓	✓	
Program for Adaptive Living Skills (PALS) Alternative		✓		✓		✓	✓	✓		✓	✓
Crisis Integrated System Pilot Project						✓					

Service	Chelan-Douglas	Grays Harbor	Greater Columbia	King	North Sound	Peninsula	Pierce	Southwest WA BH	Spokane	Thurston Mason	Timberlands
Offender Re-Entry Community Safety Program (ORSCP)				✓				✓			✓
Project for Assistance in Transition for Homeless (PATH)			✓	✓	✓	✓		✓	✓	✓	
Evidence Based/Wraparound (EBP)					✓					✓	
Wraparound with Intensive Services (WISe)					✓					✓	
Geriatric Transition Team					✓						
PORCH	✓			✓	✓		✓	✓	✓		
Trauma Informed Care					✓	✓				✓	
Free Clinic Medications		✓		✓	✓		✓			✓	
BHO Direct Service Support											
Rehabilitation Case Management	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Utilization Management and Quality Assurance	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Information Services	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Public Education	✓	✓		✓	✓	✓		✓	✓	✓	✓

Service	Chelan-Douglas	Grays Harbor	Greater Columbia	King	North Sound	Peninsula	Pierce	Southwest WA BH	Spokane	Thurston Mason	Timberlands
Crisis Telephone				✓	✓		✓				
Transportation				✓							
Interpreter Services			✓	✓	✓	✓					
Ombudsman	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
HARPS		✓	✓								
Hospital Liaison, Extraordinary Tx Plan, Housing Assistance	✓	✓	✓								
HIV Program										✓	
Residential Support (Primarily funded by ALTSA but accessed by the BHOs)											
Adult Family Home	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
ECS, Adult Family Home	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓
Specialized Behavior Support, Adult Family Home	✓	✓	✓	✓	✓		✓	✓	✓	✓	
Adult Residential Care	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Assisted Living Facility	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Enhanced Adult Residential Care	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Specialized Dementia Program	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Enhanced Services Facility								✓	✓		

Appendix D

Current State Hospital Staffing

Full Time Equivalent Staffing by Hospital

Classification (Full-Time)	WSH	ESH	Total Per Position
Active Treatment Director	0	1	1
Administrative Assistant 2	4	2	6
Administrative Assistant 3	11	8	19
Administrative Assistant 4	2	1	3
Administrative Assistant 5	1	0	1
Adult Training Specialist 3	2	0	2
Billing & Revenue Mgr	1	0	1
Budget Mgr	1	0	1
Center Dir	1	0	1
Center Dir, Center For Forensic Svcs	1	0	1
Chaplain	2	1	3
Chief Administrative Officer	2	0	2
Chief Administrative Officer/Cfo	0	1	1
Chief Exe Offr Esh	0	1	1
Chief Executive Officer, Wsh (Non-Med)	1	0	1
Chief Of Patient & Staff Safety	1	0	1
Chief Operating Officer	2	1	3
Clinical Nurse Specialist	3	4	7
Clinical Operations Director	1	0	1
Clinical/Medical Technologist 2	0	2	2
Clinical/Medical Technologist 3	0	1	1
Community Nurse Specialist	4	2	6
Community Prog Dir	1	0	1
Community Resource Program Manager	0	2	2
Compliance & Standards Mgr	1	0	1
Compliance Officer	0	1	1
Cook 1	14	2	16
Cook 2	5	4	9
Cook 3	2	0	2
Ctr Dir-Older Adults & Specialized Svcs	1	0	1
Custodian 1	77	34	111
Custodian 3	6	1	7
Custodian 4	0	1	1
Custodian 5	1	0	1
Customer Service Specialist 2	1	0	1
Data Compiler 1	0	1	1
Data Compiler 2	0	2	2
Data Compiler 3	0	1	1
Dental Assistant	3	0	3

Classification (Full-Time)	WSH	ESH	Total Per Position
Dental Hygienist 2	1	0	1
Dentist	2	0	2
Dietitian 2	4	4	8
Dir Of Medical Records	0	1	1
Dir Of Psychology	0	1	1
Dir Of Qual Management	0	1	1
Dir Of Rehabilitation Svcs	0	1	1
Dir Of Security	3	0	3
Dir Soc Wk	0	2	2
Dir, Qual & Enterprise Solutions Dept	1	0	1
Director Nutrition & Food Services	1	0	1
Dir-Organizational Development	0	1	1
Emergency Management Program Spec 1	1	0	1
Facilities Coordination Mgr	1	0	1
Facilities Planner 2	1	0	1
Financial Benefits Coordinator	0	1	1
Financial Recovery Enforcement Officer 2	2	0	2
Financial Recovery Enforcement Officer 3	3	0	3
Fiscal Analyst 1	0	1	1
Fiscal Analyst 2	0	1	1
Fiscal Analyst 3	0	1	1
Fiscal Analyst 4	0	1	1
Fiscal Specialist 1	0	5	5
Fiscal Technician 2	0	1	1
Food Service Manager 3	0	1	1
Food Service Supervisor 1	4	3	7
Food Service Worker	52	21	73
Food Service Worker Lead	4	3	7
Forensic Therapist	0	2	2
Forms & Records Analyst 1	1	0	1
Forms & Records Analyst 2	13	1	14
Forms & Records Analyst 3	1	5	6
Forms & Records Analyst Supervisor	1	1	2
Fsu Administrative Dir	0	1	1
Gpu Administrative Director	0	1	1
Habilitation Plan Administrator	4	1	5
Habilitative Mental Health Prog Dir	1	0	1
Hearings Scheduler	1	0	1
Hospital Central Service - Lead	1	0	1
Hospital Central Services - Lead	0	1	1
Hospital Central Services - Supervisor	1	0	1
Hospital Central Services Technican 1	2	0	2
Hospital Central Services Technican 2	1	0	1
Hospital Staff Plan Mgr	1	0	1
Imaging Technologist 2	2	0	2

Classification (Full-Time)	WSH	ESH	Total Per Position
Industrial Hygienist 3	1	0	1
Institution Counselor 2	63	0	63
Institution Counselor 3	66	6	72
Investigator 3	2	1	3
Investigator 4	2	0	2
It Specialist 1	1	1	2
It Specialist 2	6	0	6
It Specialist 3	4	1	5
It Specialist 4	8	3	11
It Specialist 5	3	1	4
It Systems/App Spec 6	4	0	4
Laboratory Technician 1	2	0	2
Laboratory Technician 2	1	1	2
Laboratory Technician 3	3	0	3
Laboratory Technician 4	1	0	1
Licensed Practical Nurse 2	89	5	94
Licensed Practical Nurse 4	66	19	85
Mail Processing-Driver Lead	1	0	1
Management Analyst 1	2	0	2
Management Analyst 4	1	0	1
Management Analyst 5	1	1	2
Med Asst Supt	0	1	1
Medical Assistance Specialist 3	1	0	1
Medical Transcriptionist 2	4	7	11
Medical Transcriptionist Lead	0	1	1
Medical Transcriptionist Supervisor	1	0	1
Mental Health Technician 1	328	127	455
Mental Health Technician 2	18	5	23
Mental Health Technician 3	27	12	39
Mental Health Technician 5	11	7	18
Mgr Of Forensic Social Work	1	0	1
Mgr Of Social Work Svcs - Civil	1	0	1
Nurse Executive	0	1	1
Nursing Consultation Advisor	1	1	2
Occupational Therapist 1	8	2	10
Occupational Therapist 2	0	1	1
Occupational Therapist 3	13	2	15
Occupational Therapist Supervisor	0	1	1
Occupational Therapy Assistant 2	2	0	2
Office Assistant 2	1	0	1
Office Assistant 3	28	18	46
Office Assistant Lead	6	1	7
Office Support Supervisor 1	1	0	1
Pbx & Telephone Operator	8	5	13
Pbx Chief Operator	1	1	2

Classification (Full-Time)	WSH	ESH	Total Per Position
Performance Improvement Mgr	1	0	1
Personal Services Specialist 2	1	0	1
Personal Services Specialist 3	1	0	1
Pharm Supv	1	0	1
Pharmacist, Clinical	18	7	25
Pharmacy Dir	1	0	1
Pharmacy Director	0	1	1
Pharmacy Technician 1	9	4	13
Pharmacy Technician 2	2	1	3
Pharmacy Technician Lead	1	0	1
Physical Therapist Supervisor	1	1	2
Physical Therapy Assistant 2	0	1	1
Physician 3	15	4	19
Physician 4	1	0	1
Physician Asst Cert/Adv Rn Pract Lead	0	5	5
Picu Prog Director	0	1	1
Plant Communications Coordinator	1	0	1
Printing Stockroom Worker	1	0	1
Program Coordinator	1	3	4
Program Specialist 3	2	0	2
Program Specialist 5	6	1	7
Program Support Supervisor 2	0	1	1
Psych Svcs Supv	1	0	1
Psychiatric Nurse Executive	2	0	2
Psychiatric Security Attendant	169	78	247
Psychiatric Security Nurse	59	10	69
Psychiatric Social Worker 3	54	20	74
Psychiatric Social Worker 4	3	5	8
Psychiatrist	33	14	47
Psychologist - Forensic Evaluator	32	10	42
Psychologist 3	2	1	3
Psychologist 4	25	5	30
Psychology Associate	27	0	27
Psychology Svcs Supv	1	0	1
Recreation & Athletics Specialist 2	0	8	8
Recreation & Athletics Specialist 3	8	0	8
Recreation & Athletics Specialist 4	1	0	1
Recreation Therapist 2	7	14	21
Recreation Therapist Supervisor	0	1	1
Registered Nurse 2	179	82	261
Registered Nurse 3	79	39	118
Registered Nurse 4	15	7	22
Research Investigator 3	1	0	1
Retail Clerk 1	0	1	1
Safe Team Dir	1	0	1

Classification (Full-Time)	WSH	ESH	Total Per Position
Safety Officer Assistant	2	1	3
Schedule Mgr	0	1	1
Secretary Lead	1	0	1
Secretary Senior	6	1	7
Secretary Supervisor	5	1	6
Security Guard 1	0	6	6
Security Guard 2	52	0	52
Security Guard 3	4	1	5
Sewing & Alterations Specialist 2	0	1	1
Speech Pathologist/Audiologist Spec 2	0	1	1
Stockroom Attendant 3	0	1	1
Therapies Supervisor	10	1	11
Therapy Aide	1	4	5
Therapy Assistant	4	0	4
Training Coord	1	0	1
Warehouse Operator 1	0	1	1
Warehouse Operator 3	0	2	2
Wsh Medical Director	1	0	1
Total	1899	716	2615

Part-Time Equivalent Staffing by Hospital

Classification (Part-Time)	WSH	ESH	Total Per Position
Billing & Revenue Mgr	1	0	1
Chaplain	0	1	1
Clinical Operations Director	1	0	1
Cook 1	0	3	3
Custodian 1	1	4	5
Dental Assistant	0	1	1
Dental Hygienist 2	1	1	2
Dentist	0	1	1
Food Service Worker	2	7	9
Food Service Worker Lead	0	1	1
Institution Counselor 2	2	0	2
It Specialist 3	0	1	1
Laboratory Technician 2	1	0	1
Licensed Practical Nurse 2	3	1	4
Mental Health Technician 1	38	55	93
Occupational Therapist 3	1	0	1
Occupational Therapy Assistant 2	0	1	1
Pbx & Telephone Operator	1	4	5
Personal Services Specialist 3	0	1	1
Pharmacist, Clinical	0	1	1
Pharmacy Technician 1	0	1	1
Physician 3	2	1	3

Program Coordinator	0	1	1
Psychiatric Security Attendant	12	14	26
Psychiatric Security Nurse	0	1	1
Psychiatrist	1	0	1
Psychologist 4	1	0	1
Recreation Therapist 2	0	1	1
Registered Nurse 2	5	22	27
Registered Nurse 3	3	1	4
Registered Nurse 4	1	0	1
Retail Clerk 1	0	2	2
Security Guard 1	0	7	7
Total	77	134	211

Appendix E

Schedule for Stakeholder Interviews in WA

Monday, August 8 Labor and Industries, Seattle

Schedule	Organizations
9-11am: MH Providers including E&T leadership (Northwest WA)	<ul style="list-style-type: none"> • Kitsap Mental Health Services • Washington Council for Behavioral Health • National Alliance on Mental Illness • King County BHO • Valley Cities • Navos • Harborview Medical Center • Downtown Emergency Service Center
11-1pm: BHO leadership (Northwest WA)	<ul style="list-style-type: none"> • King County BHO • Community Health Plan of WA • North Sound BHO
1-3pm: Labor Unions (SEIU)	<ul style="list-style-type: none"> • SEIU 1199NW
3-5pm: Defense Councils	<ul style="list-style-type: none"> • King County Defense

Tuesday, August 9 House Rules Room in the Legislative Building, Olympia

8-10 am: MH Providers including E&T leadership (Southwest WA)	<ul style="list-style-type: none"> • World Bridgers • Greater Lakes Mental Health Care • Columbia River Mental Health Services
10 am -noon pm: BHI Executive Oversight Committee and State Agencies	<ul style="list-style-type: none"> • Office of Forensic Mental Health Services • Developmental Disabilities Administration • Division of Behavioral Health and Recovery • Home and Community Services • Health Care Authority
noon-2pm: BHO leadership (Southwest WA)	<ul style="list-style-type: none"> • Thurston Mason BHO

Wednesday, August 10 OB2 Auditorium, Olympia

8-10 am: Legislative Staff	<ul style="list-style-type: none"> • Senate Committee Services • Senate Majority Coalition Caucus • House Democratic Caucus • Office of Program Research • House General Government & Information Technology Committee
10 am-noon pm: Local Government and Jails/Police agencies	<ul style="list-style-type: none"> • Washington State Association of Counties • Association of Washington Cities • Washington Association of Sheriffs and Police Chiefs
noon-2 pm: Courts/Judges	<ul style="list-style-type: none"> • King County Superior Court • Administrative Office of the Courts
2-4 pm: State Leadership on Integrated Care	<ul style="list-style-type: none"> • Health Care Authority
4-6 pm: WA Hospital Association members (conf call)	<ul style="list-style-type: none"> • Washington State Hospital Association

Thursday, August 11 Western State Hospital, House Rules Room in the Legislative Building, Olympia

9-11 am: Western State Hospital	<ul style="list-style-type: none"> • Western State Hospital leadership
1-3 pm: Health Care Authority	<ul style="list-style-type: none"> • Health Care Authority
3-5 pm: BHO leadership	<ul style="list-style-type: none"> • Salish Behavioral Health Organization
3:30-4 pm: Veterans Affairs	<ul style="list-style-type: none"> • Department of Veterans Affairs

Monday, August 15 DSHS Spokane Region 1 CSD Training Center

Schedule	
8-10 am: Mental Health Providers and BHO leadership	<ul style="list-style-type: none"> • Frontier Behavioral Health • Spokane County BHO • Spokane County Jail • Providence Sacred Heart Medical Center • Spokane Addiction Recovery Centers • Sunshine Terrace • Lutheran Community Services Northwest • Okanogan Behavioral Healthcare • Native Project • Passages Community Link
1-3 pm: Local Government	<ul style="list-style-type: none"> • Spokane County
3-5 pm: Defense Council	<ul style="list-style-type: none"> • Spokane County Defense

Tuesday, August 16 Eastern State Hospital, Sacred Heart

9-11 am: Eastern State Hospital	<ul style="list-style-type: none"> • Eastern State Hospital leadership
1-3 pm: WA Hospital Association members (Sacred Heart)	<ul style="list-style-type: none"> • WA Hospital Association • Providence Sacred Heart Medical Center and Children's Hospital
3-5 pm: WA Hospital Association members (Wenatchee, via conference call)	<ul style="list-style-type: none"> • WA Hospital Association • Confluence Health

Stakeholder Interview Conference Calls

Thursday Aug 18 11:30 am -1 pm MH Providers	<ul style="list-style-type: none"> • Comprehensive Healthcare
Monday Aug 22 10:30-11:30 am Courts/Judges	<ul style="list-style-type: none"> • King County Superior Court
Tuesday Aug 23 10-11 am (continued Weds Aug 24 8:30-9:30am) Managed Care Organizations / Early Adopter Region	<ul style="list-style-type: none"> • Community Health Plan • Molina
Tuesday Aug 23 2-3 pm BHI Executive Oversight Committee and State Agencies	<ul style="list-style-type: none"> • DSHS Division of Behavioral Health and Recovery
Friday Aug 26 8-8:45 am Courts/Judges	<ul style="list-style-type: none"> • Spokane County Superior Court

Appendix F

WA Behavioral Health System Questionnaire

Completed by (name, title):	
Organization:	
Date completed:	

Section 1. Behavioral Health Organizations Financing Structure

#	Question	Answer
1	<p>What are BHOs and state hospitals' current methods for utilization management and hospital diversion?</p> <p><i>(Utilization management is defined as a set of standards and procedures to determine whether a given type or level of care is appropriate and necessary for any given patient.)</i></p>	
2	Should BHOs be incentivized to decrease state bed utilization? If yes, what incentives do you think would be the most and the least effective?	
3	From your perspective, what existing barriers/challenges do BHOs and state hospitals face regarding effective utilization management?	
4	What are the pros and cons of the current financing structure for mental health services?	
5	What are the pros and cons of putting the BHOs at full risk for state hospital utilization?	

#	Question	Answer
6	What are the pros and cons of putting the state's Aging and Long-Term Support Administration at full risk for state hospitalization for aging persons?	
7	What are the pros and cons of putting the state's Developmental Disabilities Administration at full risk for state hospitalization for persons with intellectual and developmental disabilities?	
8	What are the pros and cons of the state purchasing beds in other inpatient settings outside of state hospitals, e.g. other psychiatric hospitals?	
9	What roles do you see state hospitals and BHOs playing in accountability of discharge planning and community and transition options?	
10	What roles of accountability in discharge planning and community and transition options could be better clarified between state hospitals and BHOs?	
11	How do you see the roles of state hospitals and BHOs changing as WA moves to an integrated health system?	

Section 2. State Hospital Admission Practices for both Civil and Forensic Patients

#	Question	Answer
12	What are the most common diagnoses among state hospital patients?	
13	What is the prevalence of co-occurring disorders among state hospital patients?	
14	What is the ratio of forensic to civil commitments in the state hospital populations?	
15	Do the state hospitals conduct a standardized acuity assessment of all persons, civil and forensic, entering the hospital? If so, what does that process include and how are the results used?	
16	How do barriers to timely admission differ for the forensic versus civil populations?	
17	What are the pre and post coordination efforts with the transferring provider for admitted state hospital patients?	
18	Does the admission process include goal setting with the patient?	
19	What do you see as the biggest deficiency in the current admission processes?	
20	How would you recommend improving state hospital admission practices?	

Section 3. State Hospital Discharge Practices for both Civil and Forensic Patients

#	Question	Answer
21	When does discharge planning begin? What policies and tools are used to guide this process?	
22	What are the main factors taken into consideration in determining whether a patient is ready for discharge? Who makes the determination?	
23	Is the outpatient provider and/or BHO involved in treatment and discharge planning? If yes, how is the availability of structured placements, such as adult family homes, residential treatment facilities or skilled nursing facilities, taken into account during discharge planning?	
24	What are the main barriers to discharge for both civil and forensic patients?	
25	How do barriers to timely discharge differ for forensic verses civil populations?	
26	How is continuity of care for patients considered in discharge planning, such as coordination with providers that will serve the patient at discharge?	
27	Is the patient assigned a case manager at discharge? Is any follow-up conducted once the patient has been discharged?	
28	Are there waiting lists for discharges from the state hospitals? If so how, many persons are on each list? What is the median number of days a person waits for discharge?	
29	How can the state's housing programs be changed to allocate more housing to persons being discharged from state hospitals and what would the impacts of this change be?	

#	Question	Answer
30	Could staffing organization in the hospitals be changed to promote a more timely discharge process? Are there shortages of particular kinds of staff that affect the timeliness of a person's discharge?	
31	Are there sufficient community services to take care of persons being discharged from state hospitals? If not, what services are lacking?	
32	How could state hospital discharge practices be improved?	
33	How could State hospital and BHO discharge coordination practices be improved?	

Section 4. Clinical Questions

#	Question	Answer
34	What are the characteristics of patients who are the most likely to be served successfully in a community setting instead of a state hospital?	
35	What population do you believe is currently not served by either state hospitals or BHOs?	
36	What portion of the current state hospital patient population do you believe could be stepped down to a community setting?	
37	What interventions do you typically employ to prevent psychiatric hospitalization?	
38	Are there other interventions that you would like to employ but are not able to? What are the limitations that prohibit this?	
39	What processes would facilitate successful step-down and transitional placements for state hospital patients?	
40	What is the availability of co-occurring substance use disorder treatment services at the state hospitals and community based providers?	
41	What are the barriers to community-based treatment?	
42	To your knowledge, are there staffing problems at the hospitals, either in terms of the level and types of staff available or how staff are used?	
43	To your knowledge, are there staffing problems in community settings such as evaluation and treatment centers?	

Section 5. Additional Information

#	Question	Answer
44	What are three areas in the behavioral health system that if improved would most positively impact patients?	
45	What other recommendations would you like to provide?	

Appendix G

Stakeholder Response Log

MH Providers and BHOs/MCOs

Ref. #	Issue	Root Cause	Risk and Negative Consequences	Possible Solution
1.	“Integration” in early adopter regions is really just integration of funding streams and not true integration of services	Lack of funding for full integration; there was no rate increase for providers	The state should not push forward with full integration without a far better understanding on what the cons are. Providers see cons as lack of system control with multiple MCOs and lack of actual plans for integration	Wait for results of early adopter regions before pushing forward with full integration throughout the state. System changes take years to sort out and settle
2.	State Hospital model is dysfunctional	It is an antiquated institutional system run by the government without innovation that does not embrace the recovery model	State Hospitals are allowed to run themselves the way they want; Union rules for hospital are problematic	Keep the state Hospitals for the forensic population and do voucher system to pay the free market to take care of the civil population outside the state Hospitals
3.	Confusion in discharge process between State Hospital and BHO	Ambiguity in discharge process	Lack of low income housing; lack of evaluation and treatment beds	More funding for permanent supportive housing as well as community beds; would cost less than repeat hospitalizations
4.	IDD, Dementia and TBI patients at the state Hospitals	Lack of capacity elsewhere to house these patients; convoluted building licensure rules from AL TSA	These patients do not get better and therefore should be served in specialized settings not in the psych hospitals	More funding for long term care specialized housing
5.	No services for SUD at WSH	Lack of funding for SUD	People need treatment for SUD and mental health issues at the hospitals or they end up decompensating quickly when returned back home	Fund SUD services at state hospitals
6.	State hospitals will not take patients when providers need them to	Capacity	Providers have to pay the bill in local community settings where they do not belong and therefore services suffer down the latter	Create reliable State Hospital system when that is the necessary level of care

Ref. #	Issue	Root Cause	Risk and Negative Consequences	Possible Solution
7.	Lack of evaluation and treatment beds	Mindset that money was not specifically allotted for them even though capitated system	Causes a trickledown effect of capacity issues throughout the entire system	Providers should be more innovative and realize evaluation and treatment beds are a good investment and they do not just have their one BHO as their customer. Can fill with other BHO clients and private insurance
8.	State Hospital staff are siloed	Management of hospital	Doctors, social workers, etc. all have different bosses who don't communicate so the units don't function properly	Re-align staffing structure so all staff in a unit report to one leader
9.	State does not state their goal for the mental health system in contracts	Legislation and state contracts are not prescriptive	The state is not getting what it wants out of the mental health system they buy	State needs to know the goal, whether its discharging people from state hospitals, focusing on the recovery model, etc. and hold BHOs/MCOs accountable for the specific goal via contracts
10.	State Hospital admission waitlist priority is a mystery	Hospitals are not held accountable to disclose admission decision protocols	No acuity test is performed resulting in some patients getting in before others who may be less in need	Have a standardized admission process based on acuity
11.	PACT (Program of Assertive Community Treatment) funding without housing funding	Lack of funding for housing	PACT is a great program but can't be successful without housing for individuals	More funding for housing as well as community beds
12.	Lack of mental health workforce	Low provider rates lead to lack of workforce because they are unable to compete with physical healthcare industry	Even with Medicaid expansion more provider hours are not possible due to lack of workforce, which leads to even lower rates and the inability to keep patients out of the hospital due to lack of staff in outpatient system	Increase provider rates and incentivize people to join mental health workforce
13.	Patients benefits are not ready when the patient is clinically ready for discharge	A different system is in charge of coordinating benefits; such as SSI and Medicaid: Home and Community Services, and they are not run efficiently	Patients are ready for discharge but may decompensate by the time the benefits have been worked out	Start coordinating benefits and discharge planning sooner
14.	There are no specialty/secure/long term	As long as the current State Hospital system is around the	There is not enough capacity in the state hospitals and it is not the best place for treatment due	Separate the forensic and civil population and carve out geriatric. Treat the civil and

Ref. #	Issue	Root Cause	Risk and Negative Consequences	Possible Solution
	facilities outside of State Hospitals	community will not invest in providing those services	to lack of recovery model as well as admission and discharge planning	geriatric populations separately in the community in specialty/secure/long term facilities

Legislative Staff

Ref. #	Issue	Root Cause	Risk and Negative Consequences	Possible Solution
15.	The state keeps increasing funding for State Hospitals without any positive impacts	Multiple lawsuits resulted in the state putting more funding in the budget for the hospitals	The increased funding has not resulted in systemic change. 2 wards at WSH were supposed to open (1 civil 1 forensic) but did not due to staffing issues	The state should be more direct in the use of funds for systemic change necessary to improve the mental health system in the state
16.	DSHS says the barriers to discharge at the state hospitals are LTC, BHO and housing yet they have oversight of all 3 areas	Agencies operate in siloes	The system is fragmented so there is finger pointed at who is actually accountable and at fault	DSHS needs to be accountable to the different kind of systems it manages
17.	Funds were poured into the community setting but just sit in the county reserves	ACA and Medicaid expansion	BHOs should be spending the funds they have; lots more clients through expansion yet service hours are not going up	Direct BHOs to spend down their reserves more responsibly and increase provider hours

State Departments

Ref. #	Issue	Root Cause	Risk and Negative Consequences	Possible Solution
18.	Not enough community resources to take care of specialized population	1/3 rd of people stuck at WSH could be discharged if there were more availability in the community for: Adult Family Homes, Skilled Nursing Facilities and Independent Living Facilities	These patients stay at WSH for way longer than necessary, but community resources won't take them due to low rates and complexity of need	Build more capacity in the community and increase rates for hard to place patients

Local Law Enforcement/Government

Ref. #	Issue	Root Cause	Risk and Negative Consequences	Possible Solution
19.	State Hospitals take too long to file reports with court which bogs down the system	Not enough beds or workforce, so hospitals take their time on paperwork to get more time	Not getting forensic population in fast enough for competency restoration and evaluation—lead to Trueblood lawsuit. On the civil side—boarding lawsuit	More hospital bed capacity and workforce to get people through the system to comply with the law
20.	Recidivism rates are high at jails and WSH for behavioral health patients	Lack of step down services and housing	More expensive for the state if people go back into the BH and criminal justice system	Divert BH clients from jail by instituting more mobile crisis units who coordinate with first responders, police officers and fire fighters. Also fund more emergency shelters for these people to be diverted to
21.	Jails are overcrowded with people who have BH issues and they should be treated in the BH system	Lack of capacity for inpatient beds in the state hospitals	More expensive for the county instead of the state to house these people in jails where they are not equipped to handle them	State needs to take responsibly and create more BH capacity
22.	Discharge process at state hospitals ambiguous and differ based on whims of hospital discharge person in charge	Lack of standardization of discharge process or acuity test	When a certain person goes on vacation patients can get placed more easily in the community	Standardize discharge practices so a single person doesn't have the ability to bog down the system
23.	Forensic patients are stuck at ESH without much hope for ground privileges or discharge	Bad PR due to Phillip Paul escaping from ESH	Suspending individual civil liberties by continuing these strict and possibly unlawful activities	Hold ESH accountable for treating NGRI patients appropriately
24.	ESH cherry picks which forensic patients they want to keep	They are incentivized to say more difficult patients are competent so they don't have to care for them anymore and they get sent to jail	Unfair system of competency restoration	Don't let ESH have sole discretion on how it runs and let a singular doctor decide competency

State Hospitals

Ref. #	Issue	Root Cause	Risk and Negative Consequences	Possible Solution
25.	Insufficient amount of funding throughout the year	Baseline budget provided by state underestimates costs	Insufficient amount of resources to support hospital operations and patient care	State Hospital work with State Legislation to determine appropriate budget.

Ref. #	Issue	Root Cause	Risk and Negative Consequences	Possible Solution
26.	Some patients who are ready for discharge are staying for long periods of time.	BHOs do not have to pay for their clients admitted to the state hospital, therefore have less incentive to transfer their client back into the community	Hospital setting no longer appropriate care for patients; Inpatient bed availability stalls	Place BHOs at some risk for their clients who are admitted to state hospitals. Example: a risk model that is split into three categories: (1) 1/3 do not meet level of care (decertified, can be served elsewhere) (BHO pays 100% level of care), (2) another 1/3 shared risk (deeper level of care 50%, mutually incentivize between state hospital and BHO) and (3) 1/3 no risk (hospital pays 100%)
27.	Confusion between hospital and BHOs on criteria for discharge readiness.	No standardization among wards in hospital on discharge readiness criteria.	Variation in when a patient is ready for discharge; Some patients may be discharged too soon or stay in hospital longer than appropriate; Disagreement between BHOs and state hospitals on discharge readiness	A standard discharge readiness criteria or assessment should be developed and used across all wards in state hospitals.
28.	Long term care patients are staying in state hospital longer than necessary and appropriate	The long term care industry is for profit therefore can reject more difficult and expensive patients	Some long term care patients do not receive the appropriate care in the appropriate setting; Bed availability for other patients is stalled	State opens up their own LTC facility, SNF, memory care and other facilities to serve long term care patients. This will result in less referrals to private care facilities who will then have to become more efficient, decrease rates and accept patients
29.	Some individuals should while others should not be admitted to the state hospital.	DMHPs evaluation while with good intentions may not be effective or reliable as a clinician's assessment	Individuals needing hospital level of care do not receive it, while others admitted to the hospital would benefit most from community based services.	Clinician assessment should be considered when individuals are placed on admit list to the state hospital.
30.	Large number of patients ready to discharge remain in the hospital.	Insufficient community placements available to meet the varying needs and challenges of patients	Hospital setting no longer appropriate care for patients; Bed availability insufficient to accommodate individuals on admit wait list	Funding to build appropriate housing; Build more facilities to meet needs of different patient populations; Increase rates so facilities may accept more patients

Ref. #	Issue	Root Cause	Risk and Negative Consequences	Possible Solution
31.	Lack of resources at hospitals to treat different populations' needs	State hospitals have become a place to house and care for individuals when there is nowhere else in the community for them	Patients may receive inappropriate care; Over utilization of available beds causing wait lists to grow; Patients on discharge lists remain in hospital when they no longer need that level of care	State needs to determine what role the state hospitals should have in the BH System and provide sufficient resources to hospitals and the community so they can best serve individuals with behavioral health needs.
32.	System clogs due to 1114 flips	1114 flips are given priority over other admits	Patient delays in receiving appropriate treatment; Bed capacity decrease in hospital	-
33.	Understaffed	Salary is not competitive; Unable to attract qualified professionals	Employees are assigned more work than ideal; Patients may not be receiving efficient care	Improve hospital environment, offer more competitive salary rates

Community Hospitals/Washington State Hospital Association

Ref. #	Issue	Root Cause	Risk and Negative Consequences	Possible Solution
34.	Inappropriate use and prolonged length of stay at ED for patients with psych complaints	Insufficient amount of community services and placement. Cheaper for the state to have someone in the hospital than in a residential facility.	Patient delayed from receiving appropriate treatment; inappropriate use of limited hospital resources; decreased capacity for appropriate ER admissions; increased liability for violating patient civil rights or for injury to hospital staff or other patients	Increase home and community services; Increase rates for assisted living programs; Increase supportive housing programs (PACE program is a good model)
35.	Conflict between whether MCO or BHO pays hospital for psych services provided to patients	Interpretation of WAC at BHO level varies. For voluntary patients, BHO denies authorization. MCOs deny authorization as well since they expect BHO to pay for BH services in the hospital.	Hospital is burdened with unpaid services and must navigate billing between BHOs and MCOs	Full integration of behavioral and physical health to streamline processes and for ownership of payment accountability
36.	Difficult to obtain Certificate of Need (CON)	Ambiguity with CON criteria process	Delays or denials in expanding needed psych inpatient beds;	Psych beds should be exempted from the CON process, but with provisions that would open the CON process to prevent the cherry picking of patients

Ref. #	Issue	Root Cause	Risk and Negative Consequences	Possible Solution
37.	Confusion with use of inpatient psych bed when it is no longer needed	No regulation or guidance provided by state on	Unused bed that could be serving needs of other types of patients	Provide regulation or guidance on bed conversion for beds established through CON process
38.	High prevalence of patients with behavioral health needs and substance use disorder (SUD)	Lack of resources to support recovery; Low rates for Medicaid providers treating SUD	Patients with co-occurring diseases do not receive appropriate care	Need more resources for chemical treatment in residential or facility setting
39. 3	Some patients require detainment but are kept at ED	DMHP process flawed. DMHP has 24 hours to see patient and may come at the moment when patient happens to be more calm. DMHP not looking at what the patient was admitted for. Physicians have to defer clinical judgement to someone less qualified.	Patients are not having their psych needs met; overcrowding and overutilization of ED	Clinical judgment needs to be considered in DMHP assessment

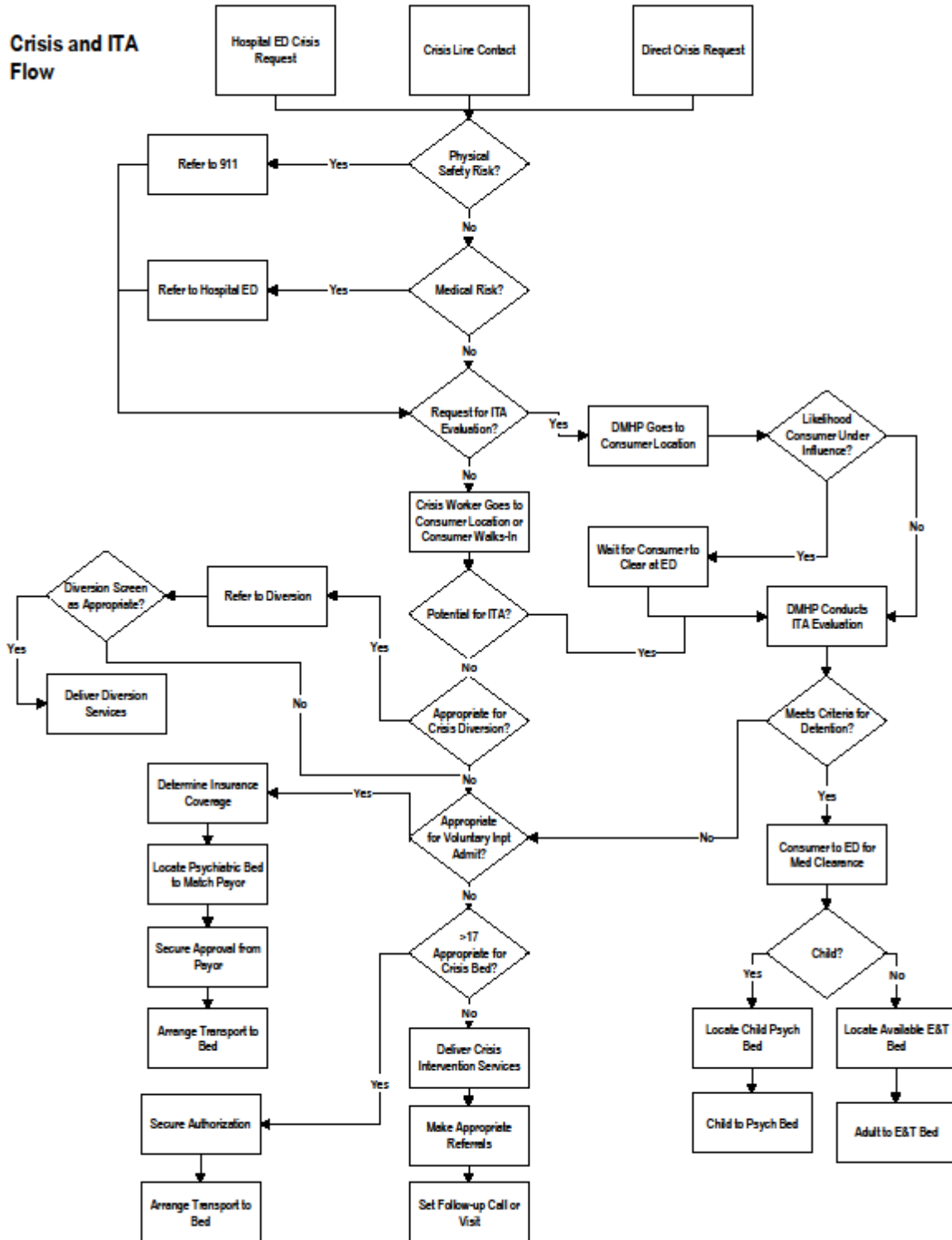
Unions

Ref. #	Issue	Root Cause	Risk and Negative Consequences	Possible Solution
40.	Nurses are assigned a high patient load	Hospitals are understaffed, salary is low and does not attract talent, poor retention. An ideal staffing model exists, but is not actualized.	Nurses are overworked and underpaid which may detract them from staying at the hospitals; Lowers employee morale; Patients could be receiving more efficient care	Salary rates should be more competitive; Adhere to staffing model
41.	Many vacant positions in the hospital	Salary is not competitive; Unable to attract qualified professionals	Staff is overworked; Lowers employee morale; Patients could be receiving more efficient care	Salary rates should be more competitive; Allow hire of ANRPs as providers but do so in a way that does not involve legislative overreach
42.	High turnover, particularly for peer counselors and case managers with BA or Masters	Counselors and case managers are assigned too many cases; Salary is not competitive	Staff is overworked; Lowers employee morale; Patients could be receiving more efficient care	Define what the appropriate workforce and reach a reasonable salary
43.	No resiliency in the BH workforce system	No training programs or defined career ladders exist	Staff turnover as they move on to better positions elsewhere (private or non-clinical setting),	Provide more structure in workforce development to create a BH pipeline: offer trainings and develop a career ladder

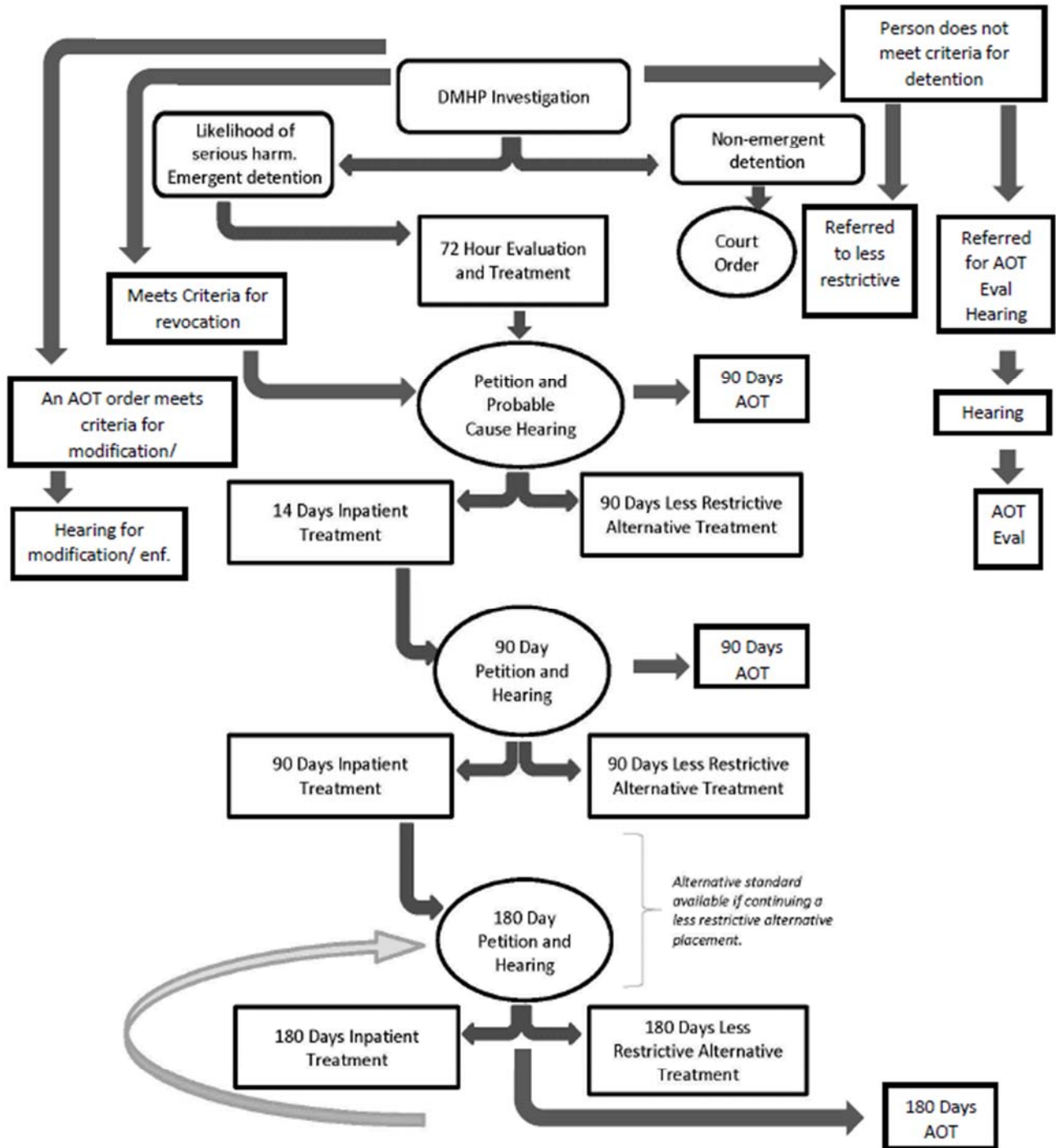
Ref. #	Issue	Root Cause	Risk and Negative Consequences	Possible Solution
			Staff under supported or not sufficiently trained over time	
44.	Patients remain on the discharge list too long	Appropriate facilities and housing support do not exist in the community	Patients do not receive appropriate level of care; Backlogs system in getting patients admitted that need hospital level of care	Increase step down services in the community;
45.	Recidivism of patients returning to the hospitals	Lack of supportive services in community to help patients successfully transition	Patients do not fully recover; Overutilization of hospital resources	Develop and fund more peer counselor programs (Peer Bridger Program successful); Increase transitional support services; Provide more SUD treatment services and coping mechanisms
46.	In the outpatient settings, some patients require more time with providers but are not receiving it	Only one case rate level for outpatient benefits which disincentives providers to spend more time with patients with higher needs	Patients not receiving appropriate treatment; May cause patient to decompensate and return to hospital setting	Install greater differential in case rate that considers multiple levels of acuity

Appendix H

Crisis and ITA Service Flow Charts



Overview of the Involuntary Treatment Act Process (71.05 RCW)





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